The Dissertation Committee for Joohee Lee certifies that this is the approved version of the following dissertation:

PSYCHOLOGICAL HEALTH IN ASIAN AND CAUCASIAN WOMEN WHO HAVE EXPERIENCED DOMESTIC VIOLENCE: THE ROLE OF ETHNIC BACKGROUND, SOCIAL SUPPORT, AND COPING

Committee:

_____
Elizabeth C Pomeroy, Supervisor

_____
Calvin L Streeter

_____
Dennis L Poole

_____
Noel B Busch

_____
Thomas M Bohman

PSYCHOLOGICAL HEALTH IN ASIAN AND CAUCASIAN WOMEN WHO HAVE EXPERIENCED DOMESTIC VIOLENCE: THE ROLE OF ETHNIC BACKGROUND, SOCIAL SUPPORT, AND COPING

by

Joohee Lee, B.A., M.A., M.S.W.

Dissertation

Presented to the Faculty of the Graduate School of

The University of Texas at Austin

in Partial Fulfillment

of the Requirements

for the Degree of

Doctor of Philosophy

The University of Texas at Austin

August 2004

Dedication

To my parents who gave me constant support, encouragement, and an abundance of love

Acknowledgements

I would like to thank all of the individuals who assisted me in the completion of my dissertation. First, I would like to extend my sincere gratitude to my adviser, Dr. Elizabeth Pomeroy, for her unwavering support and insight throughout the dissertation research process, as well as her unconditional mentorship throughout the journey of my doctoral studies. In addition, I cannot fully express my gratefulness to Dr. Calvin Streeter. He understood my struggles as a foreign student and has provided me with great assistance, guidance, encouragement, and patience. I truly want to acknowledge Dr. Dennis Poole for his guidance on my dissertation. I can not forget his class which provided me with a strong commitment to teaching. I am also very grateful to Dr. Noel Busch. She gave me endless trust and support, which enable me to finish my dissertation. I am extremely appreciative of her positive influences on my career in the area of domestic violence. Finally, I truly want to acknowledge Dr. Thomas Bohman for his guidance on my new adventure in structural equation modeling. I am very fortunate in being able to have him as my committee member.

My parents and siblings have also provided support and encouragement throughout this process. My dissertation is dedicated to my parents, Yongchil Lee and Yoonoh Park, who gave me constant support, companionship, encouragement, and an abundance of love. Their love has led me to take on many things I never would have thought attainable. Siblings are also excellent to have around. Especially, my older sister JungJin Lee, who, in addition to being supportive through my degree, has always been

my friend. I have overcome many hardships because of her. My younger sisters, Jooyong Lee and Jimin Lee, and my younger brother, Wonsuk Lee, have also been supportive and helpful to me. I must further express my appreciation to Dr. Gil Choi, an adviser during my master's program at the University of South Carolina. I can not forget his prayers for me. His interpersonal warmth and dedication to social work have served as an inspiration to me throughout my graduate career.

I can not forget the time I spent here, in Austin, where I met so many good friends and colleagues. Especially, my thanks go to my Korean colleagues in the School of Social Work at the University of Texas at Austin who have been supportive though my degree and dissertation, including Jinseok Kim, Jongserl Chun, Sokho Lee, and Soyon Jung.

My great appreciation also goes to Sungbae Kim, pastor of the Korea Baptist Church of Austin, and his wife Jumin Kim, as well as to other church members, including Jiyoung Ahn, for their prayers for me.

The study would not have been successful without the research participants. Their time and effort are appreciated. In addition, I would like to extend my thanks to the staff members in domestic violence agencies in Texas and California for approving the data collection process. Special thanks go especially to the Saheli members who showed great interest in my research and provided ideas. I am also thankful for the grant I received from the Institute on Domestic Violence and Sexual Assault.

Lastly, and most importantly, I thank God who, above all, guides me and allows me to receive all the support I encounter throughout my academic career.

PSYCHOLOGICAL HEALTH IN ASIAN AND CAUCASIAN WOMEN WHO HAVE EXPERIENCED DOMESTIC VIOLENCE: THE ROLE OF ETHNIC BACKGROUND, SOCIAL SUPPORT, AND COPING

Publication No. _____

Joohee Lee, Ph.D.
The University of Texas at Austin, 2004

Supervisor: Elizabeth C. Pomeroy

This study examined the relationship between domestic violence and psychological outcomes among women who have experienced domestic violence. This study also focused on the potential mediating effects of social support and coping strategies on the relationship between violence and psychological outcomes. With two ethnic groups of Caucasian and Asian women, this study explored the explanatory role of coping and social support with regard to possible differences in psychological effects as a result of violence across ethnic groups. Structural equation modeling was used to analyze the relationships among the level of violence, perceived social support, coping strategies, and psychological outcomes, within the context of stress-coping theory and social support models.

This study consists of a sample of 100 Caucasian women and 61 Asian women who have experienced domestic violence during the past year and were recruited from domestic violence agencies in Texas and California. Central hypotheses regarding perceived social support and coping as a mediator of the relationship between domestic violence and psychological outcomes were supported in the combined group analysis. It was found that there was an indirect effect of violence on psychological outcomes through mediating variables of perceived social support and passive coping. A comparison of Caucasian women and Asian women indicated that the relationships among level of violence, perceived social support, copings, and psychological outcomes vary across ethnic groups. In the Caucasian group, there was an indirect effect of violence on psychological outcomes through the mediating variables of perceived social support and passive coping. On the other hand, in the Asian group, there was a strong relationship between violence and psychological outcomes, while the mediating effects of perceived social support and coping were not found. The implications for social work practice, policy, and future research were delineated.

Table of Contents

List of Tables

List of Figures

CHAPTER I
INTRODUCTION

1. Problem Statement

Domestic violence occurs regardless of race/ethnicity, and has serious consequences for victims' physical and psychological health. Estimates from the National Violence Against Women (NVAW) survey indicate that approximately 1.5 million women are victims of physical or sexual assault by their intimate partners each year in the United States (Tjaden & Thoennes, 1998). Nearly one out of three women experiences at least one physical assault by a partner during adulthood (American Psychological Association, 1996). According to Abbott, Johnson, Koziol-McLain, and Lowenstein (1995), it is estimated that 22-35% of emergency room visits are made by women who need medical care as a result of domestic violence. Health care costs associated with violence by an intimate partner exceed $5.8 billion each year; of that amount, nearly $4.1 billion are for direct medical and mental health care services (Centers for Disease Control and Prevention, 2003). In addition to causing injury, battered women appear to be at risk for developing serious psychological outcomes (Boes & McDermott, 2002; Coker et al., 2002; Robert, 2002). Battered women have been found to be at an increased risk for depression (e.g., Dienemann et al., 2000) and posttraumatic stress disorder (e.g., Austin, Lawrence, & Foy, 1993). These negative psychological effects are long lasting (Carmen, Rieker, & Mills, 1984; Heise, 1993), may remain unresolved because of a victim's unwillingness to access formal care (Fischbach &

Herbert, 1997), and play a primary role in the maintenance of abusive relationships (Carlson, 1997). Also, psychological distress following violence may be a significant reason for suicidal behavioral among battered women (Kaslow et al., 1998). Reducing psychological trauma related to violence has therefore been considered one of the crucial aspects of intervention with abused women.

Like other populations in the United States, domestic violence is a serious problem facing Asian American communities. Findings from the National Violence Against Women (NVAW) survey indicated that 52% of Asian and Pacific Islander women surveyed experienced physical and sexual victimization by an intimate partner in their lifetime (55% in the general U.S. population) (Tjaden & Thoennes, 1998). Since most representative sample surveys on domestic violence do not include Asians as a separate category (Lee, 2002), the prevalence of domestic violence among Asian communities has been examined in studies primarily based on community samples. According to Projct AWARE (Asian Women Advocating Respect Empowerment), about 30 % of the Asian women surveyed indicated that they experienced sexual or physical abuse by their intimate partners at least occasionally in the past year (McDonnell & Abdulla, 2001). According to a community sample of Korean women (Song, 1996), 90 out of 150 participants reported being battered by their intimate partners within the past 2 years. Tran (1997) studied 65 Vietnamese women and found that 51 out of 65 women reported physical and/or verbal abuse during the past year. Yick's (2000) Chinese American study indicated that about 20% of participants experienced physical abuse by their partners during their lifetime.

Domestic violence is a significant social problem across cultures, and the victims of domestic violence are at a greater risk for psychological distress than the general population. The purpose of this study is to examine the relationship between domestic violence and psychological health outcomes among abused Asian and Caucasian women. Despite the burgeoning empirical literature on domestic violence, victims' variations in psychological responses following domestic violence have rarely been examined. The vulnerability to such a traumatic event may be influenced by personal or environmental factors. This study examines how coping strategies and social support influence the relationship between domestic violence and psychological outcomes.

There may be a great deal of variability among victims of domestic violence with regard to the extent of their subsequent difficulties in psychological health. Some victims may suffer serious adverse outcomes, whereas outcomes for others may appear to be relatively mild. Only a few studies investigate the factors explaining such a differential. Those studies utilize stress-resistance mechanisms as a way of understating variation in responses to stressful events, and consider coping or social support a protective factor that may reduce the risk of adverse psychological health for abused women (Coker et al., 2002; Kemp, Rawlings, & Green, 1991; Mitchell & Hodson, 1983; Nurius, Furrey, & Berliner, 1992; Tan, Basta, Sullivan, & Davidson, 1995*).* Studies agree that social support plays an important role in the protection of victims from the consequences of the traumatic experience (Coker et al., 2002; Kemp, et al., 1991; Mitchell & Hodson, 1983; Tan, et al., 1995). Coping is also considered a factor which may contribute to reducing

adverse psychological outcomes of abuse (Kemp, Green, Hovawitz, & Rawlings, 1995; Mitchell & Hodson, 1983; Nurius et al.,1992).

Since the previous studies examined the impact of social support and coping on psychological consequences of battering separately, little is known about the nature of the relationships between social support and coping, and their impacts on psychological outcomes among abused women. Furthermore, there is a dearth of research examining how a victim's ethnic background influences social support and coping processes, and their relationships with psychological outcomes.

Although domestic violence is found across ethnic and racial groups, and is a serious problem facing Asian American communities (McDonnell & Abdulla, 2001; Song, 1996; Tran, 1997; Yick, 2000), very limited attention has been given to the psychological consequences of battering among Asian women. Most studies utilized samples of predominantly Caucasian women. None included Asian women, who are an ethnic minority and immigrant population. This study will be the first study exploring how Asian and Caucasian women differ as to the interplay among domestic violence, social support, coping, and psychological outcomes.

Asians' cultural values and status as an ethnic minority may influence social support and coping processes, by promoting or discouraging the use of certain types of coping and by hindering the victims from accessing or utilizing social support. Several studies (Bjorck, Cuthbertson, Thurman, & Lee, 2001; Chang, 1996; Yoshihama, 2002) reported that Asians may cope with stress differently than Caucasians, which may be explained by different cultural values and norms. In addition, desirable coping strategies,

which are found in U.S. studies, may result in negative outcomes for Asian women because of a cultural proscription against such coping acts (Yoshihama, 2002). Lee (2002) said "for Asians, disclosing domestic violence is not just a demonstration of self-assertiveness to the violence. Such an act may also mean shaming the family name and violating the virtues of perseverance and endurance, challenging male supremacy, and bringing disruption to the family" (p. 474).

Many Asian women may not have friends and family members in the United States, and a wide variety of services, which are becoming available to serve domestic violence victims or survivors, may not be available, accessible, or culturally acceptable for Asian women, especially for new immigrants. Moreover, Asians may feel that the support they receive is less beneficial because their efforts may be frustrated by cultural or language barriers, as well as a lack of knowledge about appropriate resources, such as legal services for immigrant battered women (Yoshihama, 1999). Song (1996) reported about 90% of Korean battered women surveyed had problems speaking English.

With differences in perceived social support and differences in coping responses between Asian women and Caucasian women, there may be a difference in the degree of impact of domestic violence on psychological outcomes. Therefore, this study is to explore the explanatory role of coping and social support with regard to possible differences in psychological effects as a result of violence across ethnic groups.

2. Psychological Outcomes of Domestic Violence

Domestic violence causes significant damage to the psychological aspects of victims' lives. The most frequently reported symptoms among battered women are related to posttraumatic stress disorder (e.g., Austin, et al., 1993; Golding, 1999; Hattendorf, Ottens, & Lomax, 1999; Kemp et al., 1995) and depression (e.g., Dienemann, et al., 2000; Sato & Heiby, 1992).

PTSD is a common outcome of battering (Petretic-Jackson, Witte, Jackson, 2002), which is consistently found across varied samples, such as clinical samples, shelters, hospitals, and community agencies (Hughes & Jones, 2000). The symptoms include "arousal," "avoidance," "intrusive memories," "memory loss," and "cognitive confusion" (Asmundson et al., 2000, p. 204). While the prevalence of PTSD varies from one study to the next, the prevalence of PTSD among battered women is considerable, ranging from 31% to 84% (Golding, 1999). Especially, a high prevalence of PTSD is found among shelter populations, and estimates range from 40% to 84% (Hughes & Jones, 2000). These rates are much higher compared to non-battered women. Kali, Rosen, Gruber, and Tolman (1999) reported that the rate of PTSD symptoms among non-battered women was five percent.

Previous studies (Bennice, Resick, & Mechani, 2003; Hattendorf, et al., 1999; Jones, Hughes, & Unterstaller, 2001; Kemp et al., 1995; Vitanza, Vogel, and Marshall, 1995) suggested the relationships between level of violence and PTSD, stating that the intensity of exposure to violence is a major factor in the elevation of PTSD among battered women. Several studies agree that the more severe the battering episodes and

injuries sustained, the greater the intensity of PTSD symptomology (Astin, Lawrence, & Foy, 1993; Astin, Ogland-Hand, Coleman, & Foy, 1995; Kemp, Rawlings, & Green, 1991). PTSD symptoms are also found among women who experience psychological abuse (Kemp et al., 1995; Vitanza, Vogel, and Marshall, 1995). Kemp et al. (1995) revealed that 81% of a group of physically abused women and 63% of a verbally abused group met PTSD criteria. Vitanza, Vogel, and Marshall (1995) reported that more PTSD symptoms were found among women who experienced severe psychological abuse from their partner than those who experienced moderate or no psychological abuse. Regarding sexual aggression, Bennice, Resick, and Mechanic (2003) found that sexual violence severity explained a significant proportion of the variance in PTSD beyond that which was already accounted for by physical violence severity. Hughes and Jones (2000) indicated that women who experience physical and sexual aggression exhibit greater symptoms of PTSD than those who encounter either types of abuse alone.

Depression is another prevalent psychological symptom documented in battered women (Bean & Moller, 2002; Follingstad, Brennan, Hause, Polek, & Rutledge, 1991; Gelles & Straus, 1988; Gleason, 1993; Sato & Heiby, 1992; Stein & Kennedy, 2002; Tuel & Russell, 1998; Vivian & Malone, 1997). For example, Sato and Heiby (1992) reported that about 50% of their samples of battered women met the criteria for depression. Stein and Kennedy (2002) also reported a high prevalence of depression symptoms among battered women (68%). Bean and Moeller's (2002) study reported a similar result that 63% of the women showed moderate to severe depression symptoms. Several other studies compared levels of symptoms of depression between women who experienced

partner violence and those without such victimization. For example, Tuel and Russell (1998) reported that women who experienced partner abuse had higher levels of depressive symptoms than those who have not been abused. Gelles and Straus (1988) reported depression in battered women to be as high as four times those in non-battered women. Gleason (1993) found depression rates of 63% and 81% in two samples of battered women, compared with 7% in the general population. Like PTSD, depression is found among women who experience psychological abuse, as well as physical abuse (Cascardi & O'Leary, 1992; Follingstad et al., 1991).

Several studies examined the co-occurrence of PTSD and depression among battered women. While Stein and Kennedy (2001) found that the severity of depressive and PTSD symptoms was highly correlated, Cascardi, O'Leary, and Schlee (1999) indicated that the two symptoms were moderately correlated.

3. Asian Cultures and Responses to Domestic Violence

Asian Americans are one of the fast-growing groups in the United States, comprising 4% of the overall population in 2000 (U.S. Department of Commerce, 2002). By 2050, Asian Americans will constitute around 10% of the total population (Lee, 2002). Although Asians consist of diverse groups from different parts of Asia, this study will be limited to Chinese, Korean and Vietnamese for the following reasons. First, these groups make up large Asian ethnic subgroups: Chinese Americans (21%), Korean Americans (9%) and Vietnamese American (9%) (U.S. Department of Commerce, 2002). Second, these ethnic groups are strongly influenced by Confucianism (Hong, Yamamoto, Chang

& Lee, 1993; Park & Cho, 1995; Tran & Jardins, 2000; Yamashiro & Matsuoka, 1997), which provides strict moral standards and discipline. Such Asian values and beliefs may affect how Asian women perceive domestic violence and respond to domestic violence (Lee, 2002; Merchant, 2000; Tran & Jardins, 2000).

Studies indicate that there are differences between Asian culture and Western culture which may influence victims' perceptions on domestic violence (Choi & Edelson, 1996; Lee & Cheung, 1991; Yick, 2000; Yoshioka, Dang, Shewmangal, Vhan, & Tan, 2000), their help seeking responses (Lee, 2002; Song, 1996; Tran & Jardins, 2000), and coping responses to violence (Ho, 1990; Tran & Jardins, 2000). Many studies (e.g., Dussich, 2001; Jamieson, 1993; Park & Cho, 1995; Tran & Jardins, 2000; Yamashiro & Matsuoka, 1997) discuss the impact of Confucianism in explaining different responses to domestic violence between Asians, especially East Asians and Vietnamese, and Western people.

Confucian philosophy emphasizes "close family ties, hierarchy, and order and does not stress independence and autonomy" (Ho, 1990, p. 133). Therefore, in Asian society, keeping family harmony and saving family reputation are highly valued (Ho, 1990; Lee, 2002, Yamashiron & Matsuoka, 1997). Tran and Jardins (2000) state that among Asians, "the individual is group-focused and less self-focused, which means that desires of an individual are secondary to those of the family" (p. 77). Based on these cultural values, disclosing domestic violence and seeking help from the outside may be considered breaking close family ties and loosing family face. Fear of losing family face

may contribute to Asian women being passive in response to domestic violence (Lee, 2002).

In addition to their obligation to family, obligation to children may also hinder the victims from taking action from violence. Tran and Jardins (2000) argue that the Asian women in the Untied States may not leave an abusive relationship because they fear that leaving their husbands will cause them to lose custody of their children, a common phenomena in their native countries. The authors also state that most Asian women may be uninformed of U.S. law, which has historically favored the mother.

Another Confucian discipline that may impact responses to domestic violence is male dominance over women. The Submissions, which is a major Confucian principle (Tran & Jardins, 2000), states that "women should be subservient to their fathers when young, to their husbands when married, and to their son when widowed" (Shon & Ja, 1982, p. 211-212). Tran (1997) reported that in an interview with Vietnamese battered women, the women tended to normalize abusive behaviors of their husbands because they felt that they failed to obey. Kibria (1993) states that in Vietnamese culture, "a woman is supposed to be a good wife, be physically attractive, speak well but in a careful and soft manner, and be a person of good character" (cited in Tran & Jardins, 2000, p.79). The emphasis on obedience and submission to husbands may discourage the victims from confronting and challenging the violence.

4. Purpose of the Study

Domestic violence is a significant social problem across cultures, and the victims of domestic violence are at a greater risk for psychological distress than the general population. Despite the burgeoning empirical literature on domestic violence, victims' variations in psychological responses following domestic violence have rarely been examined. The vulnerability to such a traumatic event may be influenced by personal or environmental factors. The purpose of this study is to examine the relationship between domestic violence and psychological health outcomes. This study also explores how coping strategies and social support influence the relationship between domestic violence and psychological outcomes. There has been little focus on a cross-cultural perspective of the model for the effect of social support and coping on the psychological outcomes of domestic violence. This study, therefore, explores how Asian and Caucasian women differ as to the interplay among domestic violence, social support, coping, and psychological outcomes.

The results of the study will contribute to research in social work in several important ways. First, knowledge gained from the current study will contribute to building theory to account for psychological responses to domestic violence. Advances in the theoretical literature may contribute to developing more adequate intervention strategies for victims of domestic violence. Social support and coping may explain the variability of the vulnerability among battered women. This vulnerability will be the targets of prevention and treatment. Second, the current study will provide valuable information about how the impact of domestic violence on victims' psychological

distress varies across cultures, and how social support and coping differentially contribute to victims' psychological health across cultures. It may be important to be aware of cultural impacts because culturally insensitive services are a challenge for the battered women of different cultural backgrounds. A comparison of the social support and coping strategies of Asian and Caucasian women will help service providers develop intervention and healing strategies that are culturally competent. That is, the results of the study will help the service providers to be better prepared for client diversity in terms of ethnicity, and to develop an accurate intervention strategy that addresses the needs of diverse victims.

CHAPTER II
REVIEW OF LITERATURE

This chapter consists of two sections: the first section examines factors which may influence the individuals' psychological responses to domestic violence. The second section reviews theories and proposes a model to account for variability in individual's psychological responses to domestic violence. The first section conceptualizes each factor and reviews the previous studies examining the relationships between those factors and psychological outcomes. In the second section, the author reviews stress-coping theory, social support models, and models integrating coping and social support. These theories will be a guidance to develop a theoretical model for the proposed study.

I. Factors Influencing the Individuals' Psychological Responses to Domestic Violence

1. Domestic Violence

1.1. Definition

Domestic violence, which is often used as an exchangeable term for partner violence in many studies, is defined differently across studies. Garner and Fagan (1997) define domestic violence broadly as "the nature of the acts that constitute violence and the types of relationships that qualify as domestic" (p. 54). While some studies limit the definition of domestic violence to acts of physical and/or sexual assault, others include

psychological or emotional aggression (Brewster, 2002). In terms of relationship, recent studies do not limit their definition to male-on-female violence; they may also include female-on-male violence and violence among partners of the same gender (Brewster, 2002). However, women are at a greater risk of being battered by male partners than men (Rennison & Welchans, 2000).

Roth (1997) argues that the definition of domestic violence should include any physical, emotional, psychological, and sexual abuse occurring between domestic partners. The National Crime Victimization Survey (NCVS) views domestic violence as murder, rape, sexual assault, robbery, aggravated, and simple assault committed by an intimate partner (Rennison & Welchans, 2000). In fact, recent studies emphasize the co-occurrence of physical violence and sexual violence. In one report, about 15% of wives reported non-consensual sex with their husbands and the prevalence was much higher among women who were physically abused by their husbands (Council on Scientific Affairs, 1992). Bergen (1998) reported that one half of the marital rape victims reported that they were raped immediately after or during physical abuse.

The stance that views emotional or psychological abuse as one form of domestic violence is based on the notion that abusive behaviors are acts to maintain power and control. According to Dalton and Schneider (2001), "an abusive relationship could be viewed as a relationship in which one partner systematically seeks to exert control over the other through a range of strategies which may well include but are certainly not limited to physical abuse" (p. 57). Dunphy (1999) addresses that with the intention of maintaining power and control, the abusers use "intimidation, emotional abuse, isolation,

minimizing, denying, blaming, children, male privilege, economic abuse, coercion, and threats to maintain dominance" (p. 497).

1.2. Domestic violence and psychological outcomes

A number of studies indicate that violent relationships do have serious negative psychological consequences (e.g., Dienemann, et al., 2000; Kemp et al., 1995). The studies continuously suggest that experiencing severe violence exacerbates negative psychological symptoms (Austin et al., 1993; Dienemann et al., 2000; Foy, Sipprelle, Rugger, & Carroll, 1984) and chronicity of abuse, which refers to length of the abusive relationship (Kemp, et al., 1991), increases traumatic symptoms (Herman, 1992). For example, Dienemann et al. (2000) reported that in a study of a sample of 84 women with diagnoses of depression, the severity of abuse was positively related to the severity of depression. Similarly, Austin et al.'s (1993) study, using a sample of 53 battered women, found that the level of PTSD was positively related to the severity of battering.

As well as physical abuse, psychological abuse alone has an unfavorable psychological impact, and having multiple victimization experiences exacerbate symptoms (Cocker et al., 2002; Hughes & Jones, 2000; Kemp et al., 1995; Vitanza et al.'s, 1995). Kemp et al. (1995) revealed that in a sample of 179 battered women from shelters and the community, 81% of a group of physically abused women and 63% of a verbally abused group met PTSD criteria. They also reported that battered women with PTSD exhibited more physical and verbal abuse, more injuries, and more forced sex in the relationship. In one study reviewing professional studies of battered women, Hughes

and Jones (2000) reported that women who experienced physical and sexual aggression exhibited greater symptoms of PTSD than those who sustained either type of abuse alone. Vitanza et al.'s (1995) study, using a sample of 93 women in stressful relationships recruited through newspapers and flyers, reported higher rates of PTSD symptoms among psychologically abused women who also experienced severe physical violence than those who experienced moderate or no physical violence. Coker et al. (2002), using a sample of 1152 women seeking medical care, reported that people who experienced sexual abuse by a partner exhibited a greater level of depression in comparison to those who experienced physical abuse without sexual abuse.

2. Social support

2.1. Definition

Social support is considered a multidimensional construct in previous studies, with little consensus across studies regarding how social support should be defined and conceptualized (Bates & Toro, 1999). For example, Turner, Frankel, and Levin (1983) define social support as "the perception that one is cared for and esteemed by others, who could be called upon should the need arise" (p. 69). Bates and Toro (1999) view social support as "interactions in which one individual or group directly provides another individual with a sense of connection, resources, and affirmation" (p.139). Similarly, Hobfall and Vaux (1983) conceptualize social support as "activities that enhance a person's sense of competence through receiving materials and cognitive help as well as

emotional comfort" (p. 7). These definitions encompass multifaceted aspects of social support, such as functional, structural, perceptional, and qualitative aspects.

Since social support is a broad and multifaceted concept, its measurements reflect this nature. In general, social support is categorized as either received vs. perceived or structural vs. functional (Bates & Toro, 1999). Received support is defined as support that an individual has actually received, while perceived support is viewed as support that an individual believes is available (Barrera, 1986). Qualitative vs. quantitative support is used as similar terms for perceived vs. received support. For example, Kemp et al. (1995) distinguish social support as quantitative support, which reflects "social activities with friends and number of social network contacts", and qualitative support, which indicates "perceived closeness and feeling supported" (p. 44).

Stein and Rappaport, (1986) distinguish the structural and functional dimensions of social support. According to the authors, structure characteristics of social support include "size," "role relationship," "total density," "boundary density", frequency of contact," and "regularity of contact." (p. 50). On the other hand, functional social support is related to the availability of certain types of support, including, "support, advice and feedback," "tangible assistance," and "emotional support" (Stein & Rappaport, 1986, p. 51). Therefore, the term of functional support could be discussed in three different ways of meaning: emotional, instrumental, and informational aid. Emotional support is a demonstration of love and caring. Informational support is the provision of content that the person can use to cope with personal and environmental problems and include advice suggestions, and directives, and information. Tangible

support is the provision of actual assets to people such as money, food, and transportation (Thoits, 1986).

In terms of the quality of social support, studies discuss satisfaction with and usefulness of social support (Cheung & Spears, 1995; Stein & Rappaport, 1986; Tan et al., 1995; Zea, Jarama, & Bianchi, 1995). These studies suggest that it is important to be aware that receiving assistance from others may reduce distress only if that assistance is beneficial. In other words, social support may or may not be beneficial depending on whether the support is useful or satisfactory to the recipient.

2.2. Social support and psychological outcomes

2.2.1. Types of social support and their impacts on psychological outcomes.

Many studies indicate that social support increases psychological well-being in general, and reduces the adverse psychological impacts of exposure to stressful life events (e.g., Aranda, Castaneda, Lee, & Sobel, 2001; Cohen & Wills, 1985; Cutrona & Troutman, 1986; Golding & Burnam, 1990). Cohen and Wills (1985) discuss that social support may directly increase the quality of one's life through the "provision of positive affect," "stability," and "avoidance of negative experiences" (p.311). The positive role of social support has been supported by different studies using different populations. Turner and Catania's (1997) AIDS caregiver study found that caregivers who had more frequent contact with family and friends tended to have lower levels of depression. Kim (1999) found that in a study of 174 Korean elderly immigrants, older Koreans who received more emotional and tangible supports had a lower level of loneliness. Using a sample of

1152 women seeking medical care, Coker et al. (2002) indicated that abused women who received support from friends, family, or a current nonabusive partner were less likely to suffer adverse psychological health consequences.

However, the positive relationship of social support with mental health has not been always supported by studies. The impact of social support could be more accurately examined by considering the types of social support, responses from supporters, and satisfaction. Different types of social support may be differentially beneficial to recipients. For instance, the impact of emotional support may be stronger than that of tangible assistance. Yates, Tennstedt, and Chang (1999) found that in a sample of 204 disabled elder caregivers, while emotional support mediated the adverse effects of stressors on caregiver well-being, the use of formal services did not influence the effects of the stressors on caregiver psychological outcomes. Other studies (Aaronson, 1989; Kaniasty & Norris, 1993; Lehmann, Ellard, & Wortman, 1986) reported that perceived support may differ from the support enacted. In one study reviewing professional studies of social support, Kaniasty and Norris (1993) found that perceived support, when compared with received support, has been more strongly and consistently associated with psychological well-being across studies. The concept of perceived social support, therefore, has been most frequently used to measure the impact of social support in the previous studies.

Several studies (Cheung & Spears, 1995; Dunst, Triveltte, & Hanby, 1994; Tan et al., 1995) report that instead of the amount of support received, satisfaction with that support would correlate with a positive outcome. For example, Tan et al. (1995) indicated

that in a sample of 146 battered women recruited through shelter, higher satisfaction with social support was related to better psychological health. The authors argue that satisfaction with social support appeared to be independent of the size of one's network; however, it was related with the number of close friends that they could rely on for various forms of support. Similarly, Cheung and Spears (1995), in a sample of 220 Cambodians living in New Zealand, reported that individuals who were more satisfied with the quality of support they received displayed more reduced psychiatric symptoms than those who reported less satisfied.

2.2.2. Moderating and mediating effects of social support

Many studies examining the impact of social support on psychological outcomes suggest that social support has a role in moderating or buffering stress (Billings & Moos, 1985; Brugha et al., 1990; Cohen & Wills, 1985; Dean & Lin, 1977; Fernandez, Mutran, & Reitzes, 1998; Kaslow et al., 1998; Lin, Ensel, Simeone, & Juo, 1979; Quittner, Glueckauf, & Jackson, 1990). The moderating or buffering effect of social support suggests that social support buffers the potentially adverse influence of high level of stress, while at low levels of stress the role of social support is relatively insignificant (Sarason, Shearin, Pierce, & Sarason, 1987). That is, the buffer model predicts an interaction between levels of stress and social support.

In studies of domestic violence, Coket et al. (2002), Arias (1999), and Kaslow et al. (1998) reported the role of social support as a moderator in the relationship between partner violence and psychological consequences. For example, in a sample of 285

African American women using the public health-care system, Kaslow et al. (1998) reported a moderating effect of social support, stating that abused women who reported higher levels of perceived social support were less likely to engage in suicidal behavior than those reporting less support. Cocket et al. (2002) reported that in a sample of 1152 women seeking medical care, if victims of partner violence have extensive social networks and if social resources are supportive, the adverse psychological impact of violence would be reduced.

On the contrary, Mitchell and Hodson (1983) rejected the buffering effect of social support, stating that although women who experienced partner violence were at a greater risk for experiencing low levels of social support resources (direct effect of partner violence on support), the interaction of support and partner violence severity (buffering effect) did not predict psychological outcomes in their sample of 60 battered women recruited through shelters.

Although most studies treat social support as a moderating variable, some other studies (Runtz & Schallow, 1997; Thompson et al., 2000) report social support to be a mediator. In one study using a sample of 138 women recruited through medical clinics, Thompson et al. (2000) viewed social support as a mediator based on the hypothesis that partner violence impacts support directly, which in turn mediates the effects of partner violence on distress. Their hypothesis was supported by the evidence that a previously significant direct effect of partner abuse on distress was no longer significant when social support was in the model. In one study using a sample of 301 college students, Runtz and Schallow (1997) considered social support as a mediator, indicating that the negative

impact of child psychological maltreatment on social support was apparent, which in turn negatively influenced adult adjustment.

3. Coping

3.1. Definition

Researchers view coping as ongoing strategies used in particularly stressful situations and they focus on the multidimensionality of coping (Folkman, et al., 1986; Lazarus & Folkman, 1984; Schiff, El-Bassel, Engstrom, & Gilbert, 2002). Lazarus and Folkman (1984) define coping as "the person's constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the person's resources" (p. 141). In their view, coping is "process oriented," contextually influenced by personal situation," and "a person's efforts to manage demand without a priori assumption about what constitutes good or bad coping" (Folkman, et al., 1986, p. 993).

Coping is also conceptualized as a multidimensional process, which includes cognitive and behavioral efforts (Ptacek, Pierce, & Ptacek, 2002). Although there are a variety of ways of coping, such as confrontive coping, distancing, seeking social support, accepting responsibility, avoidance, and religious coping (Fox, Blanton, & Morris, 1999; Lazarus & Folkman, 1984; Vitaliano, Russo, Carr, Maiuro, & Becker, 1985), researchers tend to dichotomize these coping strategies as active vs. passive, or emotion-focused vs. problem-focused, especially when they examine the impact of coping on psychological health. For example, Lazarus and Folkman (1984) divide coping into two dimensions:

emotion-focused coping, which "regulates stressful emotions," and *problem-focused coping*, which "modifies the circumstance creating the harm, threat, or challenge" (p. 150). Billings and Moos (1985) group different coping strategies into three categories: *active behavioral coping*, which "reflects behavioral attempts to directly deal with the problem," *active cognitive coping*, which "indicates attempts to manage one's appraisal of the stressfulness of the event," and *avoidance coping*, which "includes avoidance, denial and tension reduction" (p. 140). Similar to Billings and Moos' distinction, Suls and Fletcher (1985) classify coping as *approach coping*, which refers to "strategies that focus on the source of stress and reaction on it," and *avoidant coping*, which is "strategies that place the focus away from both the sources of stress and reaction to it" (p. 250). Finn (1985) categorizes "observable, behavioral efforts" as *active strategies* and "unobservable, cognitive or emotional efforts" as *passive strategies* (Yoshihama, 2002, p. 430). Kemp, et al. (1995) classify coping as *engagement,* which refers to problem-focused behaviors, versus *disengagement,* which includes problem avoidance, self-criticism, and social withdrawal.

3.2. Coping and psychological outcomes

3.2.1. Types of coping and their impacts on psychological outcomes.

Although many studies agree that coping strategies are related to psychological outcomes (Aldwin & Revenson, 1987; Bjorck et al., 2001; Clements & Sawhney, 2000; Josepho & Plutchik, 1994; Mitchell & Hodson, 1983; Valentiner, Holohan, & Moos,

1994), it is unclear which coping strategies are effective in dealing with stress (DeGenova, Patton, Jurich, & MacDermid, 2001).

Many studies indicate that active or problem-focused coping strategies are more effective than other strategies. For example, Mitchell and Hodson (1983) found that in a sample of 60 battered women, women who used more active coping responses and fewer avoidant responses reported less depression. Similarly, in a group of 80 battered women recruited through shelters, Clements and Sawhney (2000) found that an increase in problem-focused coping was related to decreased levels of hopelessness. In a sample of 71 adult psychiatric inpatients, Josepho and Plutchik (1994) found that people who used less adaptive coping skills showed more suicidal behaviors. Bjorck et al. (2001) addressed that in a sample of 228 college students, adaptive coping behaviors, which include problem solving, seeking social support, and positive reappraisal, predicted less distress, while maladaptive coping strategies, which encompasses self-control, accepting responsibility, and escape-avoidance, predicted greater distress. In the study using randomly selected community sample of 291, Aldwin and Revenson (1987) reported that engagement coping strategy was related to positive mental health, while disengagement coping was related to poor mental health.

Compared to positive impact of problem-focused or active coping, the relationships between emotion-focused or passive coping and psychological outcomes are more consistently supported by previous studies (DeGenova et al., 2001; Kalsow et al., 1998; Kemp et al., 1995; Penley, Tomaka, & Wiebe, 2002). For example, in one study using a sample of 87 HIV-infected individuals, DeGenova et al. (2001) reported that

those who used more emotion-focused coping exhibited more depression; however, problem-focused coping was not related to the symptoms. In the study of 179 battered women recruited through shelters and the community, Kemp et al. (1995) found that disengagement coping strategies were a predictor of PTSD symptoms, whereas engagement coping was not. In a study of 285 college students, Kalsow et al. (1998) found that active coping strategies did not protect abused women from engaging in suicidal behavior. Penley et al.'s (2002) meta-analysis of 34 studies dealing with the relationship between coping and mental health reported that although previous studies demonstrated a significant overall association between coping and psychological outcomes in general, a stronger relationship was found in the emotion-focused coping strategies than in problem-focused coping.

The effectiveness of a certain type of coping may depend on whether the stressor faced is controllable or incontrollable (Dressler, 1985; Forsythe & Compas, 1987; Littrell & Beck, 2001). Forsythe and Compas (1987) argue that for controllable stressors, active or problem-focused coping may be helpful, while for uncontrollable stressors, active coping mechanism may be less effective. In a study of a sample of 285 residents of a Black community in the rural area, Dressler (1985) found that African-American males with active coping had more psychological symptoms that those with less active coping; the author argues that active coping may not be effective under high levels of economic stress. However, Littrell and Beck (2001) reported that in a sample of 90 African American homeless, people who engaged more in problem-focused coping exhibited

fewer depression symptoms than do those using emotion-focused coping at all levels of uncontrolled stressor.

When researchers consider various coping mechanisms instead of dichotomizing them, the results display a more complex pattern. Penley et al.'s (2002) meta-analysis reported that although previous studies (e.g., Bjorck, et al., 2001; Finn, 1985; Yoshihama, 2002) considered confrontive coping and seeking social support as active coping strategies, which is assumed to give benefits to psychological outcomes, confrontive coping itself was related to negative mental heath outcomes, and the relationship between seeking social support and mental health outcomes was weak across studies. However, Penley et al. (2002) found that another type of active coping strategy, problem-focused coping, was strongly related to positive mental health outcomes across studies. Burt and Katz (1987) reported that in a sample of 113 rape victims recruited through rape-crisis centers, avoidance, anxiousness, and self-destructive coping strategies were associated with greater symptomatology, whereas expressive and cognitive coping were not related to the level of symptoms. Clements and Sawhney's (2000) study, using a sample of 80 battered women, reported that an increase in dysphoria among battered women was related with higher levels of avoidance coping and lower levels of problem-focused coping, while active seeking of social support was not related to reports of dysphoric symptoms. According to the authors, it is possible that since the women in the sample may be at a point where they perceive that they lack a source of social support, seeking social support may not have been a feasible coping option for them. Regarding religious coping strategies, Abernethy, Chang, Seidltz, Evinger, and Duberstein (2002) reported

that in a sample of 156 spouses of lung cancer patient, people who used high levels of religious coping reported high levels of depression than those who used moderate levels of religious coping. However, they found that low levels of religious coping were also related to high levels of depression.

3.2.2. Moderating and mediating effects of coping

Coping has emerged as a factor that mediates the relationship between stress and psychological outcomes (Dempsey, 2002; Huang & Gunn, 2001; Kemp et al., 1995; Lazar & Folkman, 1984; Lee & Liu, 2001; Pruchno & Resch, 1989; Runtz & Schallow, 1997; Steel, Wilson, Cross, & Whipple, 1996; Rode, Tilsm, Leweinsohn, & Steley, 1990), with a few exceptions that view coping as a moderator (Aldwin & Revenson, 1987). For example, in a sample of 120 inner-city African American adolescents, Dempsey (2002) reported coping as a mediator, stating that increased violence was shown to be related to the use of negative coping, such as avoidance, which in turn mediated the relationship between violence and psychological outcomes. Runtz and Schallow's (1997) study of 304 college students reported that child maltreatment influenced psychological adjustment via indirect effects through both active and passive coping strategies.

On the other hand, Aldwin and Revenson's (1987) study of 291 community residents reported a buffering effect of problem-focused coping, which moderates the impact of stressful episodes to different degrees. However, they reported emotion-focused coping to show only a direct effect, not a moderating effect.

4. Ethnicity

4.1. Ethnicity and social support

Ethnic differences in overall levels of social support have been examined in a number of studies (e.g., Aldwin & Greenberger, 1987; Liang & Bogot, 1994; Noh & Avison, 1996; Zea, et al., 1995). Studies consistently report that compared to Caucasian Americans, Asian Americans tend to perceive that less support is available, receive less help from others, and that the support they receive is less beneficial (Aldwin & Greenberger, 1987; Liang & Bogot, 1994; Zea, et al., 1995).

Different types of social support may be differentially beneficial. One study found that emotional support was more beneficial in alleviating distress than was instrumental support in an Asian population, which may be due to a preference in Asian cultures for their own support system, or a lack of culturally competent support (Lee, Crittenden, & Yu, 1996).

4.2. Ethnicity and coping

Several studies (Bjorck, et al., 2001; Chang, 1996; Fry & Grover, 1982; Rokach, 1999; Yoshihama, 2002) report differences in the choice of coping strategies between Asians and Caucasians, which may be due to different cultural values and norms. With few exceptions (e.g., Lee & Liu, 2001), studies (e.g., Biork et al., 2001; Chang, 1996; Fry & Grover, 1982) support that Asians are more likely than their Caucasian counterparts to engage in emotional-focused or passive coping when they face stressful events. For example, in one study comparing 160 Asian elders and 160 Caucasian elders residing in

Canada and the U.S., Fry and Grover (1982) found that Asians, who were depressed, coped more by blaming themselves. Similarly, Bjork et al. (2001) indicated that Asians used more passive coping behaviors, such as accepting responsibility and religious coping, than did Caucasians. The authors state that Asian's preferences of passive coping may result from an Asian culture of fatalism and submission to authority. The use of passive coping is frequently reported among Asian victims of domestic violence. Asian culture, which emphasizes obedience and submission to husbands, and keeping family face, may discourage the victims from confronting and challenging the violence and lead the victims to engage in passive coping (Lee, 2002; Tran & Jardins, 2000). Furthermore, in Asian culture, seeking help from police and the legal system is considered to bring shame to the family, even if they are cruelly abused (Dasgupta, 2000).

However, Chang (2001) found more complex results in a study comparing Asian American (n=45) and Caucasian American (n=49) college students. The author found that Asians used more problem-avoidance and social withdrawal strategies, but for other coping strategies, such as problem solving and emotion express, there was no difference. The author therefore suggests that although there is difference in the coping strategies between Asians and Caucasians, there is no reason to say that Asians use more passive coping and less active coping than their Caucasians.

As well as cultural differences, due to their minority status, Asians may engage more in passive coping. Studies indicate that minorities are less inclined to seek assistance from mainstream social service providers because of providers' lack of cultural competence (Chau, 1989; Gary, 1985) and the victim's lack of knowledge about services

(Block, 1981). Abraham (2000) states that Asian immigrant women's unfamiliarity with formal support systems may contribute to the women reacting passively to violence and increasing their dependency on their abuser.

4.3. Ethnicity and psychological outcomes

The extent to which the psychological outcomes of domestic violence are related to ethnicity remains unclear (Vogel & Marshall, 2001). While several studies (Gil & Anderson, 1999; Neff 1993; Norris, 1992; Rao, Diclemente, & Ponton, 1992) indicate that certain ethnic groups are more at risk for adverse psychological outcomes following stressful events, Vogel & Marshall (2001) report no relationships.

For example, Norris (1992) found that in a sample of 250 persons drawn from a community, given the occurrence of trauma events, African Americans were more likely to display stress than Whites. However, the author states that this result may be related to economic status, indicating that minorities have relatively lower economic resources than Whites. Ethnic difference in psychological responses may result from different coping strategies by ethnicity. In one study comparing community samples of Anglo (n=541), Blacks (n=387), and Hispanic (n=802), Neff (1993) discussed ethnic differences in psychological responses to stressful events with regard to coping strategies. The author reported that Mexican Americans were more likely to engage in passive coping, such as frequent or heavy drinking, which may be due to culturally prescribed fatalism, and it led to an exacerbation of psychological distress. Studies of sexual assault indicate that Asian victims' passive reactions following the victimization lead to greater negative

psychological symptoms. In one study comparing ethnic differences in the characteristics of the victims of child sexual abuse (n=2,007), Rao, et al. (1992) reported that Asian victims of child sexual abuse showed more suicide ideation, which may result from cultural pressures to internalize the problem. Gil and Anderson (1999) argue that in China, the victims could be revictimized following rape because of the cultural resistance to speak of sexual assault publicly in order to protect family honor, despite the victim's own emotional or physical pain.

On the other hand, in one study comparing African Americans (n=303), Mexican Americans (n=260), and European Americans (n=273), Vogel and Marshall (2001) reported that ethnic differences were not found for the severity of the symptoms of PTSD resulting from partner violence. Since this sample was drawn from low-income families, the authors suggest that SES contributes more to women's vulnerability to stress symptoms than does ethnicity.

5. Control Variables

5.1. Socio-economic status

Like ethnicity, the extent to which the psychological outcomes of domestic violence are related to socioeconomic status remains unclear (Vogel & Marshall, 2001). While several studies (e.g. Nicholson, 1997; Sullivan & Rumptz, 1994; Vogel & Marshall, 2001) indicate that there is a relationship between SES and psychological outcomes following stressful events, Huang and Gunn (2001) report no relationship.

For example, in a study using a sample of 141 African battered women recruited through shelters, Sullivan and Rumptz (1994) found that women from lower SES backgrounds demonstrated to be more vulnerable to the adverse psychological consequences following partner violence than their higher SES counterparts. In a study using a sample of 836 community women, which consisted of 303 African Americans, 273 Euro-Americans, and 260 Mexican Americans, Vogel and Marshall (2001) found that battered women who were at lower socio-economic status suffered more severe symptoms than those who were at higher status because when violence occurs, low income women may not seek treatment because of cost. The authors found that one half of the women who experienced partner violence and who were from a low- income community scored above the clinical cutoff for PTSD, regardless of ethnicity or abuse history. The authors, therefore, concluded that SES contributes more to women's vulnerability to stress symptoms than does ethnicity. In a sample of 447 Southeast Asian refugees, Nicholson (1997) found that refugees with lower income were more likely to be depressed than those with higher income.

Several other studies (Belle, 1990; Hall, Williams, & Greenberg, 1985) discuss the impact of socio-economic status on psychological outcomes in terms of social support. In a sample of 111 low-income mothers with children, Hall et al. (1985) reported that the association among stressors, supports and depressive symptom levels varied with demographic variables, such as marital status and employment status. The authors found that unemployed women with small networks were more likely to show depressive symptoms than unemployed women with larger networks. Belle (1990) argues that

compared to economically secure women, poor women may not be able to extract themselves from stressful relationships, because they perceive few material resources.

The impact of socio-economic status on psychological outcomes could also be explained by coping strategies. Belle (1990) argues that coping strategies may be restrained by socio-economic status. According to the author, poor women who seek help from formal systems often experience repeated failures, which may lead to the perceptions of learned helplessness. Therefore, poor women often use "palliative coping strategies that do not attempt to change the stressful situation itself, merely to dull the pain of its persistence" (Bell, 1990, p. 387).

On the contrary, in a study of 486 college students and 81 faculty members, Huang and Gunn (2001) reported that SES variables, such as education, personal income and family income, were not significantly related to the level of depression symptoms resulting from domestic violence.

Hughes and Jones's (2000) study reviewing professional literatures of battered women indicated that the following demographic factors affected mental health in victimized women across studies: number of children in the home (Gelles & Harrop, 1989; Rollstin & Kern, 1998), age of the women (Austin et al., 1993; Gelles & Harrop, 1989), and family income or employment (e.g., Bell, 1990; Dutton & Painter, 1993; Nuruis, et al., 1992; Sullivan & Rumptz, 1994). The authors conclude that "younger unemployed battered women with a relatively large number of children and with low income are more at risk to experiencing PTSD symptoms than women without those characteristics" (Hughes & Jones, 2000, p. 21). However, the authors state that except

those variables, other demographic variables have little influence mental health outcomes following violence.

5.2. Childhood sexual victimization

Many studies identify childhood sexual victimization as a risk factor for the development of negative psychological outcomes (Hein, Edward, Frances, & Deborach, 2000; Kemp et al., 1995; Schiff et al., 2002), increasing the risk for PTSD (Brown & Finkelhor, 1986; Kendall-Tackett, Williams, & Finkelhor, 1993; Paolucci, Genuis, & Violato, 2001) and depression (Paolucci et al., 2001). An earlier trauma may have continuing psychological effects and place individuals who later experience further trauma more psychological vulnerable (Astin et al., 1995).

In a study of 96 newly admitted methadone maintenance patients, Hein et al. (2000) found that women with histories of childhood sexual abuse were more susceptible to developing PTSD following a traumatic event than those without such victimization. Similarly, Schiff et al. (2002) reported that in a sample of 416 women recruited from methadone treatment programs, women with a history of childhood sexual abuse showed more depression than women without a history of childhood sexual abuse. However, the authors found that there was still an association between intimate partner violence and psychological stress, even after controlling for the confounding effects of a history of childhood sexual abuse (Schiff et al., 2002).

5.3. Religiosity

Religiosity has been shown to be related to favorable mental health outcomes in a number of studies, including higher levels of psychological well-being (Levin, Chatters & Taylor 1995; Ross, 1990; Willits & Crider, 1988) and fewer symptoms of distress and depression (Levin, Markides & Ray 1996; Musick et al. 1998). Williams, Larson, Buckler, Heckmann and Pyle (1991) suggest the religiosity served to buffer stressful life events and reduces the adverse consequences of the stressors on psychological well-being. Using battered women's sample, Astin, Lawrence, and Foy (1993) found that religiosity had a significant inverse repationship with PTSD symptomatology. On the contrary, Courtenay, Poon, Martin, Clayton, and Johnson (1992) found unsigficant relationship between religiosity and life satisfaction. Keonig, George, and Peterson (1998) found that higher intrinsic religiosity was associated with decrease from depression, while frequency of church attendance and private religious activities were unrelated to decrease.

II. Theoretical Frameworks

While numerous studies (e.g., Dienemann, et al., 2000; Janoff-Bulman, & Frieze, 1983) address that traumatic events result in adverse psychological outcomes, traumatic events and psychological outcomes do not have a simple cause-effect relation (Regehr, Memsworth, & Hill, 2001). In response to stress exposure, there may be variability among individuals. Researchers have examined factors that may influence psychological responses to stress, and identified social support and certain types of coping as protective factors against the stress (Abramson, Seligman, & Teasale, 1978; Aldwin & Revenson, 1987; Billings & Moos, 1981; Folkman, et al., 1986; Holahan & Moos, 1990; Kaniasty & Norris, 1996; Mitchell, & Hodson, 1983; Regehr, et al., 2001; Thompson et al., 2000; Quittner, et al., 1990).

Based on the assumption that being abused by an intimate partner is perceived as stressful (Carlson, 1997), and that such a stressful event does not affect all victims' psychological health to the same degree (Jackson, Petretic-Jackson, & Witte, 2002; Wyatt, Notgrass, & Newcomb, 1990), this study reviews stress coping theory, social support models, and models integrating coping and social support as a guidance to develop a theoretical model for the proposed study.

1. Stress-Coping Theory

1.1 Stress-coping theory

Stress- coping theory, which was developed by Lazarus and his colleagues (Lazarus, 1966, 1981; Lazarus & Folkman, 1984; Folkman, et al., 1986), has been used

as a powerful theoretical framework explaining the relationship between stressful events and psychological outcomes in a number of studies (e.g., Clements & Sawbney, 2000; McColl, Lei, & Skinner, 1995; Schiff, et al., 2002). According to Lazarus and Folkman (1984), coping is conceptualized as a multidimensional and ongoing process to perceived stress, which includes cognitive and behavioral efforts. The link between stressful events and outcomes may be altered by the cognitive appraisal processes and efforts to manage the situation (Ptacek, et al., 2002).

Although Lazarus and his colleagues' approach that views coping as an ongoing process is predominant in recent studies, there is another theoretical approach to defining coping, which is a structural approach. This approach views coping as either a function of personality traits or relatively stable styles or preferences (Bolger, 1990; McCrae & Costa, 1986). However, the present study is based on the former stance, which views coping as situation-specific efforts. Within this approach, cognitive appraisal is a crucial concept, which is defined as "a constantly occurring process that evaluates an encounter in terms of its implications for well-being" (Lazarus & Folkman, 1984, p. 150). That is, the stressful events do predict unfavorable outcomes, only if the individual appraises these events as harmful and threatening. Also, individuals' determination of coping strategies are influenced by whether there is coping resources and options available (Folkman & Lazarus, 1985). Therefore, perceiving the situation as harmful and uncontrollable, and perceiving resources unavailable promote emotional-focused coping, while appraising the situation as less harmful and controllable encourages problem-focused coping (Lazarus & Folkman, 1984; Ptacek et al., 2002). However, it does not

mean that people use only either emotion-focused coping or problem-focused coping in a stressful episode. Lazarus (1993) suggests that both forms of coping can reduce psychological distress and people can use both forms of coping simultaneously.

In sum, the stress-coping theory suggests that stress from the physical and social environment generates a state of internal arousal which influences coping, which in turn influences psychological outcomes (Folkman et al., 1986; Huang & Gunn, 2001). In other words, coping is a significant mediator of stressful events and their outcomes (Folkman et al., 1986). Problem-focused coping (it is referred to as active coping in some other studies) is considered in previous studies as more beneficial to mental health outcomes than emotion-focused coping (it is referred to as passive coping in some other studies) (e.g., Felton & Revenson, 1984; Mitchell & Hodson, 1983; Baum, et al., 1983). Also, problem-focused coping is found in the previous studies as a stress- resistance factor: depression, (Abramson, et al., 1978; Aldwin & Revenson, 1987; Billings & Moos, 1981; Folkman, et al., 1986; Mitchell, & Hodson, 1983) and PTSD (Aldwin & Revenson, 1987; Kemp et al., 1995). The effects of coping on psychological outcomes have been examined in terms of direct effects, mediator effects, and moderator effects.

The main effects model, or direct effect model, indicate that "coping has beneficial effects on well-being, regardless of the nature or stressfulness of the problem being faced" (Aldwin & Revenson, 1987, p. 338). The main effect of coping is supported by a number of studies (e.g., Boumans & Landeweerd, 1992; Felton & Revenson, 1984; Mitchell & Hodson, 1983; Sheu, & Hawang, 2002). In addition, studies report moderating effects or buffering effects of coping (Aldwin & Revenson, 1987) and

mediating effects of coping (Dempsey, 2002; Kemp et al., 1995; Lazar & Folkman, 1984; Pruchno & Resch, 1989; Steel, et al., 1996).

1.2 The application of stress- coping theory to battered women

The application of stress-coping theory to battered women is based on the assumption that "a woman's symptomatic responses to the battering is viewed as a reaction to a situational event or trauma rather than as an indication of personality deficits that somewhat caused the battering" (Jackson, et al., 2002, p. 279) and that "being abused by an intimate partner is likely to be perceived as stressful, and so abused women use secondary appraisal and cope with their situation" (Carlson, 1997, p. 293).

Experiencing abuse can be perceived as uncontrolled stressful situations, which may lead the victims to adopt avoidant or maladaptive coping, instead of more adaptive problem-solving coping (Schiff et al., 2002). Previous studies (Finn, 1985; Hoff, 1990; Kelly, 1988) consistently suggest that battered women are more likely to engage in passive or emotion-focused coping in comparison with the general population. This idea is grounded by the learned helplessness theory, which emphasizes the victim's "motivational impairment" and "intellectual impairment" response to violence (Laviolette & Barnett, 2000, p. 127). Motivational impairment may lead to a victim's passivity, and intellectual impairment may result in poor problem-solving (Seligman, 1975). Vitanza et al. (1995) support this theory, stating that cognitive difficulty resulting from repeated battering leads the victims to engage in ineffective and self-defeating problem solving. According to the authors, battered women may deny the incidence by placing blame for

abuse on external forces and endure the violence for the sake of some higher commitment, such as religion and tradition. Finn (1985) reports that battered women are less likely to engage in active, problem-solving strategies than the general population. Such passive coping strategies may result in the victims remaining dependent upon the batterer (Finn, 1985).

Although coping strategies of abused women have been considered passive in the comparison to non-battered women, there may be variations among battered women. Wauchope (1988) reported that as severity of violence increased, women were more likely to use active coping, particularly help-seeking, which is confronting the theory of learned helplessness and deficit model. The result has been supported by others who advocate survivor theory (e.g., Hamby & Gray-little, 1997; Straus & Kantour, 1990). Hamby and Gray-little (1997) found that women who experienced greater levels of violence exhibited more active behaviors and fewer passive responses than those who had less aggression. Straus and Kantour (1990) found that women who called the police in response to a battering experienced the most severe violence.

There may be a curvilinear relationship between level of violence and coping strategies, which hypothesizes that both women who experience low levels of violence and those who experience high levels of violence may be less likely to engage in active coping strategies than those who experience moderate levels of violence. Although there is no empirical study supporting this assumption, Carlson (1997) argues that coping may be related to stages that battered women experience in their perceptions of the abuse. According to the author, in the first stage, women may believe that the abuse is caused by

their own failings or shortcoming. Therefore, women at this stage may cope by evaluating the positive aspects of the relationship more highly than the negative parts. However, if the abuse continues despite of the women's change efforts, women may focus on changing the partner's behaviors. In the third stage, in which the abuse is escalating in severity, women may feel that the stress is uncontrollable. Women at this stage may engage in emotion-focused coping, such as avoidance. However, the author states that women may also engage in problem-focused coping such as seeking professional help. If those strategies do not succeed, finally, women may lose hope and engage in desperate coping such as suicide or homicide.

Carlson's (1997) study may support the notion that battered women engage in a variety of coping strategies to eliminate the violence, not engaging solely in either passive or active. Follingstad, Neckerman, and Vormbrock (1988) identifies various coping strategies found in battered women: "establishing meaning for the victimization," "utilizing cognitive defense styles," "attribution of blame," "learned helplessness," "a focus on change and control," "handling anger," and "positive strategies for ending the abusive relationship, such as reevaluation the violent relationship and restructuring the self" (p. 379-386).

Other factors may influence coping strategies of battered women. They include available resources (Mitchell and Hodson, 1983; Sullivan, 1991) and culture (Carlson, 1997; Lum, 1998; Yoshihama, 2002; Tran & Jardins, 2000). Mitchell and Hodson (1983) found that battered women who experienced positive support from friends and institutions were more likely to engage in active coping. In terms of culture, Yoshihama

(2002) argues that cultural values influence battered women's choices, prescribing the acceptable range of coping strategies. The author also argues that in some cultures, confronting their partners or seeking outside assistance is considered an act against their cultural norm, which make the victims to appear passive in their victimization. The author found that Japan-born Japanese Americans were less likely to use of active strategies, such as confrontation and help-seeking from the outside, and perceived those strategies as less effective than did U.S.-born Japanese Americans. The author concludes that there is a stronger degree of cultural prohibition against these active responses for the Japan-born Japanese women.

Regarding the effect of coping on psychological outcomes, while several studies report that coping strategies are associated with the level of battered women's psychological outcomes (Kemp et al., 1995; Mitchell & Hodson, 1983), some others argue that there is no relationship (Yoshihma, 2002; Kalsow et al., 1998). For example, Mitchell and Hodson (1983) found that abused women who used more active coping responses, and fewer avoidant responses reported less depression. Kemp et al. (1995) found that disengagement coping was associated with an increase in the extent of psychological distress.

On the other hand, Kalsow et al. (1998) found that active coping strategies did not protect abused women from engaging in suicidal behavior. Similarly, Yoshihama (2002) indicated that there was no relationship between the type of coping and psychological distress of battered women. However, she found that there was a relationship between the perceived effectiveness of active and passive strategies and psychological distress, stating

that for the U-S born women, the higher the perceived effectiveness of active strategies, the lower their psychological distress; and for the Japan-born, the higher the perceived effectiveness of passive strategies, the lower their psychological distress. However, for the Japan-born respondents, the more effective they perceived active strategies, the worse off they were in terms of psychological distress. The author explains the results, addressing that "the use of active strategies of itself may be detrimental to the psychological well-being of Japan-born women, because such strategies are culturally incongruent" (Yoshihama, 2002, p. 447).

2. Social Support Models

2.1 Social support models

Social support models are based on the assumption that exposure to stressful life events lead to adverse psychological outcomes, and social support reduces, or buffers the adverse impacts (Thoit, 1986). There are a number of studies supporting the role that social support plays in positive psychological outcomes in stressful events (Aranda et al., 2001; Billings & Moos, 1985; Brugha et al., 1990; Cohen & Willis, 1985; Cutrona & Troutman, 1986; Kaslow et al., 1998; Monroe, Bromet, Connell, & Stemer, 1986; Thompson et al., 2000). While there is general consensus that social support is a desirable product that is beneficial to health, there are two general models explaining how social support operates: the buffering model and the addictive model (direct model) (Weinberger, Tierney, Booher, & Hiner, 1990). Weinberger et al. (1990) demonstrate the differences between the buffering effect and the addictive effect of social support:

> The buffering model suggests that when individuals are exposed to stressors, strong social support systems mitigate adverse health consequences; however, in the absence of stressors, social support is not associated with health status. Alternately, the addictive model suggests that strong social support systems are beneficial to individual, independent of their exposure to stressors (p. 503).

Cohen and Wills (1985) advocate the addictive role of social support, indicating that social support is protective and can prevent the occurrence of stress. They state that "a generalized beneficial effect of social support could occur because large social networks provide people with regular positive experiences and a set of stable, socially rewarded roles in the community. This kind of support could be related to overall well-being because it provides a positive effect, a sense of predictability and stability in one's life situation, and recognition of self-worth. Integration in a social network may also help one to avoid negative experiences that otherwise would increase the probability of psychological or physical disorder" (p.311).

On the other hand, the buffer model predicts an interaction between the levels of stress and social support. For example, when people have high stress, satisfying social relationships will protect them from the negative impact of stress (Dean & Lin, 1977). This model has been supported by numerous studies (e.g., Billings & Moos, 1985; Brugha et al., 1990; Dean & Lin, 1977; Fernandez, et al., 1998; Kaslow et al., 1998; Lin, Simeone, & Ensel, & Juo, 1979)

A few studies consider social support a mediator (Kim, 1999; Thompson et al., 2000; Quittner, et al., 1990; Yates, et al., 1999), which suggests that high levels of stress

are associated with a lowered perception of social support, which in turn is associated with higher levels of adverse psychological symptoms.

Due to the multifaceted nature of social support, social support models consider which facets of social support are strongly influencing the stress-health process. Two major dimensions, perceived support and received support, have dominated the research. Interestingly, Norris and Kaniasty (1996) argue that in received social support, there are a greater number of studies revealing no effects or negative effects on psychological health. However, the authors do not devalue the benefits of received social support. Rather, they state that the effect of received support on psychological distress may be mediated by perceptions of support availability. In one study reviewing more than 40 studies of the role of social support, Cohen and Wills (1985) conclude that consistent evidence for the buffering effect of social support is found among studies in which the social support measures the "perceived availability" of social support.

2.2 The application of social support models to battered women

Many studies consistently support that, when compared to non-battered women, battered women experience a lack of tangible and emotional support available (Browne, 1997; Dobash, Docash, & Cavanagh, 1985; Gelles, 1979; Mitchell & Hodson, 1983; Sullivan, Tan, Basta, Rumptz, & Davidson, 1992). The relative lack of social support may be due to the increased control of a partner, which in turn isolates the victim from family and friends (Browne, 1993; Dobash et al., 1985; Mitchell & Hodson, 1986).

Studies find that lower levels of social support are related to greater symptomatology among battered women (Arias, 1999; Cocker et al., 2002; Giles-Sims, 1998; Kemp et al., 1995; Tan et al., 1995; Thompson et al., 2000). For example, Giles-Sims (1998) found that women with less social support experienced more symptoms because the victims tended to stay for longer periods of time in abusive relationship. Coker et al. (2002) indicated that abused women who received support from friends, family, or a current nonabusive partner were less likely to suffer adverse mental health consequences. Thompson et al. (2000) reported that higher levels of partner violence were related to lower levels of perceived social support. They also mentioned that social support mediated the relationships between abuse and distress, indicating that women who experienced high levels of partner violence were related to lower levels of social support, and this led to higher levels of symptoms. On the other hand, Arias (1999) argues that social support moderates an association between partner violence and mental health outcomes.

Tan et al. (1995) examine the impact of satisfaction with social support as well as the impact of the availability of social support. The authors found that in a sample of battered women, social support was related to overall well-being, such as depression and mastery. They found that women with a larger total number of supporters showed higher levels of mastery. Regarding satisfaction, those women who were satisfied with the social support they received were less depressed and had a higher overall quality of life (Tan et al., 1995). Similarly, Mitchell and Hodson (1983) found that the number of supporters, the nature of the supporter's responses to the battering, and the availability of social

support all contributed to psychological outcomes. The authors, for example, reported that more avoidant responses from friends were associated with greater levels of depression, while more empathic responses were associated with higher self-esteem (Mitchell & Hodson, 1983). Bybee and Sullivan (2002) say that access to community resources also related to the battered women's quality of life. They assessed access to community resources by asking women about the effectiveness in obtaining resources across several areas, such as housing, education, transportation, etc.

3. Models Integrating Coping and Social Support

Although most studies of battered women examine social support's and coping's association with psychological outcomes separately, studies of other populations, such as caregivers, utilize models integrating social support and coping in relation to psychological outcomes (e.g., Aneschensel, Pearlin, Mullan, Zarit, & Whitlach, 1995; Lawton, Moss, Kleban, Glicksman, & Rovine, 1991; Yates et al., 1999). These studies tend to focus on the association between social support and coping, and predominantly suggest that social support is coping assistance (McColl et al., 1995; Nurius, et al., 1992; Thoits, 1986). These studies indicate that individuals with greater social support may use more problem-focused or active coping and less avoidant or passive coping.

McColl et al. (1995) summarize the professional studies dealing with the relationship between coping and social support. The authors state that the relationship between coping and social support could be made for either direction: one direction is related to the assumption that individual's coping method impacts social support, by

sensitizing the availability of certain types of support; the other direction may occur when the perceived availability of certain types of social support would determine one's secondary appraisal of the problem, which in turn lead to selecting certain types of coping. The authors, citing several articles (e.g., Manne & Zautra, 1989; Wethington & Kessler, 1986), conclude that the latter position has been literally supported. For example, Manne and Zautra (1989) found that women who perceived that support was available used relatively positive coping strategies, whereas those who experienced criticism from the supporter used less adaptive and emotional coping approaches. Wethington and Kessler (1986) found that the perceived availability of support allowed one to successfully activate coping resources.

However, McColl et al. (1995) state that the relationships between social support and coping may be an "on-going feedback loop" (p. 396). Their idea is supported by Folkman and Lazarus's (1985) idea, which suggest that social support and coping may be developed in such a way as to be strengthening to one another. In this manner, the relationship between social support and coping may be complementary (McColl et al., 1995). Fondacaro and Moss (1987) support the complementarity of coping and social support: "perceived social support influences coping through information, advice or simply psychological bolstering"; and "coping influences the perceived availability of social support, by enhancing the potential for the development and maintenance of relationships" (cited in McColl et al., 1995, p. 397).

Although McColl et al. (1995) suggested various models explaining the relationships between coping and social support, their empirical study reported that social

support affected coping, but coping did not affect social support. The authors, finally, concluded that social support should be viewed as coping assistance.

The notion that views social support as coping assistance has been supported by other studies (e.g., Nurius et al., 1992; Thoits, 1986). Thoits (1986) views social support as coping assistance in terms of helping the person to identify and use specific coping strategies. Similarly, Nurius et al. (1992) consider social support to be a factor which mobilizes effective coping responses, stating that limited support resulted in distortions in coping efforts by abused women. Mitchell and Hodson (1983) found that those who experienced positive formal support from institutions, and those who did not experiences avoidant responses from friends, were more likely to use active behavioral coping strategies. Cutrona and Troutman (1986) through the previous studies (Cohen & McKay, 1984; Schaefer, Coyne, & Lazarus, 1981) argues that social support facilitates the maintenance of self-esteem in times of stress, which in turn links high levels of self-esteem to adaptive coping behaviors, which may eliminate the source of stress. Cohen and Wills (1985) state that the provision of a range of social support resources may either inhibit maladjusted responses or facilitate effective coping strategies in the facing stressful episode. Cronkite and Moos (1984) reported that women with higher degrees of perceived social support used less avoidance-coping strategies and showed less depressive symptoms than women with a low degree of perceived social support.

III. Development of the Theoretical Model for the Proposed Study

Based on the previous studies, the proposed study develops a theoretical model, which may examine factors affecting psychological health following domestic violence and explain variability in the psychological responses. In this model, coping strategies and social support mediate the relationships between domestic violence and psychological outcomes.

1. Coping as Mediator

For coping to mediate the relationships between the level of violence and psychological outcomes, the level of violence must be related to active coping and passive coping, and those coping strategies must be related to psychological outcomes. In addition, when mediator is statistically controlled, a previous significant association between the level of violence and psychological outcomes must no longer be significant or must be reduced significantly in effect size. This assumption was developed based on the previous studies on domestic violence which indicate that the level of violence is related to coping strategies (Finn, 1985; Follingstad, et al., 1988; Gondolf et al., 1988; Hamby & Gray-little, 1997; Hoff, 1990; Kelly, 1988; Schiff et al., 2002; Wauchope, 1988), and coping strategies are related to mental health (e.g., Clements & Sawhney, 2000; Josepho & Plutchik, 1994; Mitchell & Hodson, 1983). However, there are contradictory views, regarding whether the relationship between level of violence and coping is positive or negative. The assumption that exposure to partner violence leads to less active or less problem-focused coping and more passive or more emotion-focused

coping is based on the learned helplessness theory. This theory suggests that cognitive difficulty resulting from repeated battering leads the victims to engage in ineffective and self-defeating problem solving (Seligman, 1975). This theory is supported by several studies (Finn, 1985; Hoff, 1990; Kelly, 1988), which suggest that battered women are more likely to engage in passive or emotion-focused coping, in comparison to general population. Also, this assumption is supported by advocates who view domestic violence as uncontrollable stressful situations. For instance, experiencing abuse can be perceived as an uncontrolled stressful situation, which may lead the victims to adopt avoidance or passive coping, instead of more adaptive problem-solving coping (Schiff et al., 2002).

On the other hand, some studies report opposite results, which are supported by the survivor theory. Wauchope (1988) reported that as the severity of violence increased, women were more likely to use active coping, particularly help-seeking, and the idea has been supported by others who advocate the survivor theory (e.g., Gondolf et al., 1988; Hamby & Gray-little, 1997). Other research also finds that battered women rate high in terms of help-seeking behaviors (Campbell, Miller, Cardwell, & Belknap, 1994; Hutchison & Hirschel, 1998). Straus and Kantour (1990) found that women who called the police in response to a battering experienced the most severe violence.

The current study assumes that as the severity of violence increases, women will be less likely to use active coping and more likely to engage in passive coping. Regarding the relationships between types of coping and psychological outcomes, the current study assumes that an increase in the use of active coping and a decrease in the use of passive coping will lead to reduced negative psychological symptoms, which is supported by

numerous studies (e.g., Clements & Sawhney, 2000; Josepho & Plutchik, 1994; Mitchell & Hodson, 1983). Although there is inconsistency in defining coping across studies, in general, active coping includes problem-focused and seeking help, and passive coping consists of emotion-focused, avoidance, and self-criticism (e.g., Bjorck et al., 2001; Lazarus & Folkman, 1984; Vitaliano et al., 1985).

2. Social Support as Mediator

Although many studies of social support consider social support a moderator, in the current study, social support is assumed to be a mediator. For social support to mediate the relationship between the level of violence and psychological outcomes, the level of violence must be related to social support, and social support must be related to psychological outcomes. In addition, when mediator is statistically controlled, a previous significant association between the level of violence and psychological outcomes must no longer be significant or must be reduced significantly in effect size. The role of social support as a mediator represents the nature of domestic violence. Domestic violence is defined not only as a violent act but also as the control of partner. An increase in the level of violence means an increase in the control of the partner. Therefore, women who experience more severe and frequent violence may experience more isolation from family, friends, and formal networking, which leads to the lack of available social support. Low levels of social support are related to greater symptomatology (Gilies-Sims, 1998; Tan et al, 1995). Thompson et al.'s (2000) study of battered women supports the role of social support as a mediator.

Perceived social support will be considered because perceived social support, when compared with received support, is more strongly and consistently associated with psychological health across studies (Kaniasty & Norris, 1993). Among different types of social support, this study considers emotional support, tangible support, and informational support.

3. Social Support as Coping Assistance

In addition to the role of a mediator, social support is assumed to influence coping strategies. Adequate social support will encourage the victims to engage more in active coping and less in passive coping. That is, people who are more likely to perceive social support as available may engage more in active coping than those who perceive low levels of available social support. This assumption is supported by previous studies which view social support as coping assistance and coping resources (e.g., Nurius, et al., 1992; Thoits, 1986).

4. Confounding Effects

There will also be control variables in this study. In fact, psychological responses to violence are influenced not only by coping and social support, but also by other socio-economic factors, such as employment, number of children in the home, duration of relationship with current partner, and childhood sexual abuse. These variables were selected based on Hughes and Jones's (2000) study reviewing professional literatures of battered women. They found that previous studies consistently report employment and

number of children in the home to be significant factors influencing victim's psychological outcomes. Several studies (Browne, 1993; Herman, 1992) suggest that duration of abusive relationship influences victim outcome. Also, the impact of childhood sexual abuse on psychological health is supported by previous studies (e.g., Hein, et al., 2000; Kemp et al., 1995; Schiff et al., 2002). This study also considers religiosity a control variable, which is based on the previous studies indicating that the religiosity served to reduces the adverse consequences of the stressors (Levin, Markides & Ray 1996; Musick et al. 1998).

CHAPTER III
RESEARCH QUESTIONS AND HYPOTHESES

1. Research Questions

1) Does the level of violence relate directly to adverse psychological outcomes and/or is it mediated by coping strategies and perceived social support?

2) Does the perceived social support influence coping strategies?

3) Does the theoretical model of relationships among level of violence, perceived social support and coping strategies predict psychological health among two groups of battered women, Asian and Caucasian?

2 Hypotheses

2.1 Expected direct effects

This model identifies the following variables as having significant direct effects on victim's psychological outcomes: level of violence, active coping, passive coping, and perceived social support. Another interest of this study is to examine the direct effect of perceived social support on coping.

Hypothesis 1. Level of violence has a direct effect on psychological outcomes. That is, more severe violence produces increased levels of adverse psychological outcomes.

This hypothesis is based on the previous studies indicating that the severity of abuse is positively related to the severity of depression and PTSD (e.g., Austin et al., 1993; Dienemann et al., 2000; Foy, et al., 1984). Also, since previous studies find that having multiple victimization experiences exacerbates symptoms (Follingstad et al., 1991; Hughes & Jones, 2000; Kemp et al., 1995; O'Leary, 1999), level of violence will be represented by the summed scores of a scale which consists of physical abuse, psychological abuse, sexual abuse, and injuries.

Hypothesis 2. Perceived social support has a direct effect on adverse psychological outcomes. That is, greater perceived social support leads to decreased adverse psychological outcomes.

This hypothesis is based on the previous studies indicating that social support increases psychological well-being in general, and reduces the adverse psychological impacts of exposure to stressful life events (e.g., Aranda, et al., 2001; Cohen & Wills, 1985; Cutrona & Troutman, 1986; Golding & Burnam, 1990). Also, perceived support, when compared with received support, is more strongly and consistently associated with psychological health across studies (Kaniasty & Norris, 1993).

Hypothesis 3. Active and passive coping has a direct effect on psychological outcomes. That is, more active coping and less passive coping produce less adverse psychological outcomes.

This hypothesis is based on the previous studies indicating that people who use more active coping and less passive coping report less negative psychological symptoms (e.g., Clements & Sawhney, 2000; Josepho & Plutchik, 1994; Mitchell & Hodson, 1983). Although there is inconsistency in defining coping across studies, overall, active coping includes problem-focused activities and seeking help, while passive coping consists of avoidance, self-criticism, and wishful thinking (e.g., Bjorck et al., 2001; Lazarus & Folkman, 1984; Vitaliano et al., 1985).

Hypothesis 4. Perceived social support influences active coping and passive coping. That is, greater perceived social support leads to increased active coping and decreased passive coping.

This hypothesis is based on the previous studies which view social support as coping assistance. Therefore, social support may help the person to identify and use specific coping strategies (Mitchell & Hodson, 1983; Nurius, et al., 1992; Thoits, 1986). Adequate social support would be a factor which mobilizes effective coping responses, while limited support would result in distortions in coping efforts.

2.2. Expected indirect effects

This study also identifies several variables which have an indirect effect on

victim's psychological outcomes. The following hypotheses identify the indirect effects via three variables: active coping, passive coping, and perceived social support.

Hypothesis 5. Level of violence influences adverse psychological outcomes via indirect effect through mediating variables of perceived social support.

Although many studies consider social support a moderator, in the current study, social support is assumed to be a mediator. That is, high levels of violence are associated with a lower perception of social support, which in turn are associated with higher levels of adverse psychological symptoms. This assumption is supported by Thompson et al.'s (2000) study of battered women.

Hypothesis 6. Level of violence influences adverse psychological outcomes via indirect effect through mediating variables of active coping and passive coping.

This hypothesis is based on the previous studies indicating that traumatic events are related to coping strategies, and those coping strategies are related to psychological outcomes (e.g., Dempsey, 2002; Huang & Gunn, 2001; Kemp et al., 1995; Lazar & Folkman, 1984; Lee & Liu, 2001). Although there are inconsistent results in terms of the direction of the relationship between the level of violence and coping strategies, the present study assumes that as the severity of violence increased, women will be less likely to engage in active coping strategies and more likely to use passive coping strategies.

2.3. Multi- group comparison

This tests whether the theoretical model of relationships among level of violence, social support and coping predicts psychological health among two groups of battered women, Asian and Caucasian.

Hypothesis 7. Structure of the relationships among level of violence, perceived social support and coping is equivalent across the Caucasian and the Asian groups.

This hypothesis is exploratory. This assumption is developed by studies discussing ethnic differences in social support and coping (e.g., Bjorck, et al., 2001; Chang, 1996; Yoshihama, 2002). Asians' cultural values and status as an ethnic minority may influence their social support and coping process by promoting or discouraging the use of certain types of coping and by hindering the victims from accessing or utilizing social support. In addition, as Yoshiham (2002) argues, desirable coping strategies, which have been found in U.S. studies, may result in negative outcomes for Asian women because of a cultural proscription against such coping acts. Regarding social support, a wide variety of services, which are becoming available to serve domestic violence victims or survivors, may not be available, accessible, acceptable, or affordable for Asian women. Therefore, Asians may feel a greater lack of social support than their Caucasian counterparts. In addition, social support may be less beneficial for Asians in reducing the trauma following domestic violence.

CHAPTER IV
RESEARCH DESIGN AND METHODOLOGY

This chapter presents in four major sections: instruments, translation, population and sampling procedure, and data analysis plan.

1. Instruments

1.1. Level of domestic violence

Level of domestic violence was measured by the Revised Conflict Tactics Scales (CTS2; Strauss, Hamby, Boney-McCoy, & Sugarman, 1996), which is the recently revised version of the original Conflict Tactics Scale (Straus, 1979), the most widely used scale to measure intra-family violence (Straus, & Gelles, 1990). The four violence-related subscales of the CTS2 were used: physical assault (12 items), injury (6 items), sexual coercion (7 items), and psychological aggression (8 items). Items in each scale ask how many times the participants have experienced a specific abusive act, like being kicked, or the consequences of such an act, like visiting a doctor in the past one year.

Responses were coded on an eight-point Likert scale, ranging from one (never happened) to seven (occurred more than 20 times). The CTS2 have demonstrated good internal consistency for all subscales, which ranges from .79 to .95, as well as adequate construct and discriminant validity (Straus et al., 1996). CTS 2 has been used extensively in cross-cultural and subcultural research, including Korean samples (Shin, 1995), Vietnamese samples (e.g., Nguyen, 2002), and Chinese samples (e.g., Yick, 2000).

1.2. Depression

Depression was assessed by the CES-D (Center for Epidemiologic Studies Depression Scale) (Radloff, 1977). The CES-D is a 20-item scale that was designed to measure self-reported depressive symptoms. The CES-D measures a range of cognitive, affective, motivational, and somatic symptoms. Respondents were asked to indicate how frequently they had experienced the symptoms within the past week. Responses were coded on an eight-point Likert scale, ranging from one (rarely or none of the time) to four (most or all of the time). The CES-D has very good internal consistency with alphas of .85 for the general population and .90 for the psychiatric population (Fisher & Corcoran, 1994). The CES-D has been reported to possess excellent concurrent validity, good known-groups validity and good discriminant validity (Fisher & Corcoran, 1994). Also, the CES-D has been used extensively in cross-cultural and subcultural research, including Korean samples (Oh, Koeske, & Sales, 2002) and Chinese samples (Cheung & Bagley, 1998).

1.3. PTSD

The PTSD Checklist (PCL-C; Weathers, Litz, Herman, Huska, & Keane, 1993), which is a 17-item, self-report instrument correspond to the symptoms associated with the DSM-IV diagnostic criteria for posttraumatic stress disorder, was used to measure PTSD symptoms, such as intrusion, avoidance, and arousal. The PCL asks participants to rate the level at which they were bothered by each of 17 symptoms occurring over the past month. Responses were coded on a five-point Likert scale, ranging from one (not at

all) to five (extremely). The PCL has been reported to have an internal consistency coefficient of .94 (Blanchard, Jones-Alexander, Buckley, & Forneris, 1996). Test-retest reliability for the PCL-C has been reported at .96 (Weathers et al., 1993). Also, the PCL-C has been reported to possess excellent concurrent validity (Blanchard et al., 1996).

1.4. Perceived social support

Perceived social support was assessed by the Perceived Social Support scale (PSS), a 15-item scale that was designed to measure an individual's confidence that adequate support would be available if it were needed. The social support resources include emotional support, informational support and tangible support. The scale consists of items from the Interpersonal Support Evaluation List (Cohen & Hoberman, 1983) and the Social Provision Scale (Russell & Cutrona, 1984). Responses were coded on a six-point Likert scale, ranging from one (strongly agree) to six (strongly disagree). Higher scores indicate more perceived social support. The PSS has good internal consistency with an alpha of .90 (Thompson et al., 2002) and good validity (Norris & Kaniasty, 1996).

1.5. Coping

The Revised Ways of Coping Checklist (WCCL; Vitaliano, Russo, Carr, Maiuro, & Becker, 1985), which was originally developed by Folkman and Lazarus (1980), was used to assess coping efforts in response to battering. This is a 42-item, self-report checklist, which was designed to assess cognitive and behavioral coping strategies used

to manage a stressful life encounter. Participants were asked how often they engaged in different coping activities in response to battering. All response choices were ranked from one to four, “Never Used,” “Rarely Used” “Sometimes Used,” and “Regularly Used.”

Two subscales of WCCL, problem-focused and seeking social support, were used to measure the degree of using active coping. On the other hand, three subscales of WCCL, avoidance, self-blame, and wishful thinking, were used to measure the degree of using passive coping. The researcher obtained a score for each coping subscale by summing appropriate item scores on the scale. WCCL subscales have demonstrated good reliability (coefficient alpha range from .76-.83; Vitaliano et al., 1985) and validity in a number of different samples (Falkum, Olff, & Aasland, 1997).

1.6. Control and demographic variables

To assess the impact of partner violence, social support, ethnicity and coping on psychological outcomes, the following variables were considered control variables: duration of relationship with current partner, number of children living with the victims, employment status, childhood sexual victimization (under 18 years old), and religiosity. For Asian participants, level of acculturation was measured by level of English fluency, close friends, food preferences, and TV/video preferences. These variables were used as indicators of level of acculturation (Marin et al., 1987). Religiosity was measured by Short-Form of Santa Clara Strength of Religious Faith Questionnaire (SCSORF; Plante & Boccaccini, 1997). This questionnaire is 5-item measure scored on a 4-point scale

measuring strength of religious faith. Research has found coefficient alphas between .94 and .95. Age, marital status, length of relationship with the current partner, family income, level of education, and religion were asked. However, these variables were included for the purposes of describing the sample of battered women who participated in this study.

2. Translation

All instruments were translated into Korean, Chinese, and Vietnamese by bilingual Korean, Chinese, and Vietnamese graduate students at the University of Texas at Austin. A blind backtranslation by other Korean, Chinese and Vietnamese students was used to check for accuracy, sensitivity, and validity of the translation. Finally, both the English and translated versions of the instruments were reviewed by Korean, Chinese, and Vietnamese staff members working with victims of domestic violence. The reviewers were asked to examine the confirmatory of meaning between each item of the English version of the instruments and its translated versions into Korean, Chinese, and Vietnamese. Items were modified based on the reviewer's comments.

3. Populations and Sampling Procedure

Because of practical limitations, a non-probability purposive sampling strategy was used. Since the current study focuses on abused women, the study population was predominantly either shelter residents or women who contact domestic violence agencies. "Abused women" included individuals who have experienced domestic violence during the twelve months preceding their involvement in the study. Participants were recruited

beginning in September 2003, resulting in a sample size of 161 women (100 Caucasian; 61 Asians) through nine domestic violence agencies which are located at middle and large urban areas in Texas and California. These areas are known as cities where large Asian populations reside. Also, these areas are all located in urban areas, which may provide similar levels of social services to the clients. Although this sampling strategy may reduce site variations, differences in the service quality among agencies may remain uncontrolled.

The prospective participants were obtained by contacting staff members who are in the position to allow the researcher to contact potential participants about research participation. The researcher and dissertation supervisor sent a co-signed letter to the contact person to ask for permission. After receiving permission, the researcher and/or a researcher assistant visited the agency to meet potential participants. Prior to conducting the survey, the research was presented to potential participants as an anonymous and voluntary survey, with no names or identifying information requested. The purpose of the study and responsibilities involved in participation were discussed. Then, information about informed consent, confidentiality, potential risks and benefits of participating in the study was also discussed. The participants were told that they could at any time withdraw from the study. Also, they were also informed that the services they received or may receive from the agencies would not be affected by their participation in the study. Potential participants then read the informed consent and decided whether or not to participate.

About 30 to 45 minutes were required for the participants to complete the questionnaire. The questionnaires were written in English, Korean, Chinese, and Vietnamese. The participants took the survey in an available language. After distributing the survey questionnaires, the participants were given an opportunity to ask questions, and then they were left alone to finish the questionnaire. The participants were given a yellow envelop in which to put the completed questionnaire. Completed surveys were returned to researcher. All participants who took this survey received a $10 Wal-Mart gift card. To maintain confidentiality, all data was stored in locked cabinet.

4. Data Analysis Plan

4.1. Structural equation modeling

The Structural Equation Model (SEM) was used to test research hypotheses in this study. This model has been used to understand and establish relationships among theoretical constructs for the following reasons: first, there is the ability of SEM to incorporate measurement error into the estimation of relationships between constructs; second, SEM permits the representation of constructs by several indicators (Anderson & Gerbing, 1988). The use of SEM procedures has several advantages (Hays, Marshall, Wang, & Sherbourne, 1994). First, SEM permits simultaneous assessment of multiple dependent variables in a single model. Second, SEM enables examination of both indirect and direct effects of one variable on another. Third, SEM allows for examining the relations among latent variables and measured variables.

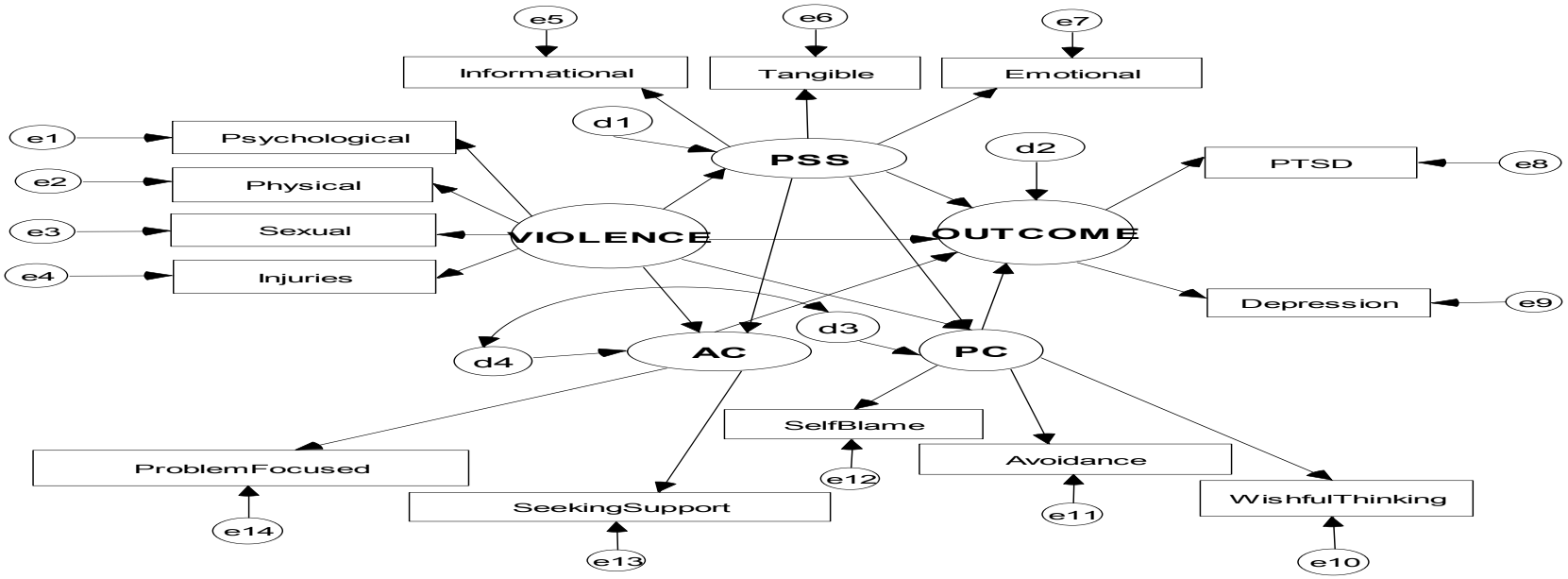
This analysis consists of two models, a measurement model and a structural equation model. The measurement model deals with the relationship between a set of observed variables and latent variables. Observed variables are those that can be measured, whereas latent variables are those cannot be measured. On the other hand, the structural model specifies the direct and indirect relationship between latent variables (Schumacker & Lomax, 1996). All paths in both measurement and structural models are estimated and evaluated simultaneously and the SEM permits modeling of mediating effects.

4.2. Analytic procedure

AMOS 5 was used for SEM procedures. The proposed model in the present study included five latent variables. In the current study, the relations between the observed measures of physical, psychological, sexual abuse, and injuries to their corresponding latent construct of level of violence (VIOLNCE) were specified. The relations between the observed measures of PTSD and depression to their corresponding latent construct of psychological outcome (OUTCOME) were also specified. The relations between the observed measures of seeking support and problem-focused coping to their corresponding latent construct of active coping (AC) were also specified. The relations between the observed measures of avoidance, self-blame and wishful thinking to their corresponding latent construct of passive coping (PC) were specified. The relationship between the observed measures of emotional, tangible, and informational supports to their corresponding latent construct of perceived social support (PSS) were also specified. The

linkage between the indicator variables and their underlying latent construct is portrayed in Figure 4.1 Circle represents latent variables, rectangles represent measured variables. Error terms for the measured variables are represented byEs. The residuals (or disturbance) for the endogenous variables are represented by Ds.

Figure 4.1 Hypothesized Conceptual Model



Note: Violence: Level of Domestic Violence; PSS: Perceived Social Support; AC: Active Coping; PC: Passive Coping; Outcome: Psychological Oytcomes

CHAPTER V
RESULTS

This study examined the relationship between domestic violence and psychological outcomes among abused women. In addition, this study assessed how social support and coping strategies affect the relationship between violence and psychological outcomes. With two ethnic groups, Caucasian and Asian, this study explores the explanatory role of social support and coping with regard to possible differences in psychological effects as a result of violence across ethnic groups. Structural equation modeling was used to determine whether the hypothesized model fit the sample data, within the context of stress-coping theory and social support models.

The present chapter consists of two sections: Descriptive Analysis and Structural Equation Modeling Analysis. The first section provides descriptive statistics on the characteristics of the participants and the observed variables. In the second section, structural equation modeling analyses are outlined: 1) to evaluate whether the hypothesized model provided a reasonable fit to the data, 2) to assess the association among level of violence, social support, coping, and psychological outcomes, and 3) to evaluate differences between groups (Caucasian vs. Asian) on these relations.

I. Descriptive Analysis

1. Descriptive Statistics of the Demographic Variables

One hundred seventy three women participated in this study. The participants were recruited from nine domestic violence agencies, which are located at middle and large urban areas in Texas and California (Table 5.1). While all Caucasian samples were obtained from domestic violence agencies in Texas, Asian samples were recruited from Texas and California. Of those 173 surveys, 12 surveys were eliminated from the analysis due to any of the following criteria: 1) a participant was not of Asian or Caucasian ethnicity; 2) a preponderance of participant's data was missing; 3) a participant has never experienced domestic violence during the twelve months preceding their involvement in the study.

Table 5.1 Information on Participating Agencies

Agency	Area	Area Size	Characteristics	Asians (N=61)	Caucasians (N=100)
Agency 1	TX	Urban/ Large	Mainstream	6	34
Agency 2	TX	Urban/ Middle	Mainstream	5	48
Agency 3	TX	Urban/ Middle	Mainstream	.	12
Agency 4	TX	Urban/ Large	Mainstream		6
Agency 5	TX	Urban/ Middle	Asian focused	3	.
Agency 6	TX	Urban/ Middle	Immigrant focused	5	.
Agency 7	CA	Urban/ Large	Asian focused	17	.
Agency 8	CA	Urban/ Middle	Asian focused	17	.
Agency 9	CA	Urban/ Middle	Immigrant focused	8	.

Table 5.2 presents demographic data on the sample. Of the remaining 161, 62 % were Caucasian women, while 38 % were Asian women. Among Asians, 23% were

Koreans (n=14), 41% were Chinese (n=25), and 36% were Vietnamese (n=22). These women described themselves as Asian women living in America rather than Asian Americans. Therefore, throughout the findings and discussion, these women were described as Asian women. Approximately 63 % were living at shelter when they were involved in this study. Approximately 35% were employed, either full-time or part-time. Forty two percent are currently living with at least one child under 18 years old. Of the women in the sample with children, most had one or two children (82.4%). Approximately half of the participants were currently in a marriage relationship with batterers, 16.4% were divorced, and approximately 30 % were never married to a batterer. Participant ages ranged from 21 to 70 with a mean age of 38 (SD = 10.42). Approximately half of the participants reported that the last abuse episode occurred during the past one month, about 30% reported two months to five months, and 23% reported six months or over. Approximately 40% of the participants had at least one sexual abuse incident during childhood and adolescence. In terms of religious affiliation, about one third of the total sample identified themselves as Protestant Christian (31.9%), 14.4% as Catholic, 14.4% as Buddhist, 23.8% as others, and 15.6% as non religious. The mean value of religiosity was 2.09[1]. The average length of the participants' relationship with the batterer was 68 months (SD = 81.11), with a range from six month to 22 years and 6 months. Approximately 30% of the participants graduated high school or got a GED, 33.5% attended at least some college, and 16 % graduated a 4-year college. About 63% of the participants reported a family income for the past year below $10,000; 13.3 %

[1] Religiosity was measured by a questionnaire which is 5-item measure scored on a 4-point scale measuring strength of religious faith. Higher scores indicate stronger religious faith.

earned between $10,000 and $19,999; 11.4% earned between $20,000 and $ 29,999; 8.2% earned between $30,000 and $39,999; and about 10% had a family income over $40,000. Among Asians, the mean value of acculturation was 2.19[2].

Table 5.2 Participants' Demographic Characteristics

Characteristics	All		Caucasians		Asians	
	N	%	N	%	N	%
Living at shelter						
Yes	102	63.4%	88	88.0%	14	23.0%
No	59	36.6%	12	12.0%	47	77.0%
Employment						
Employed	56	34.8%	35	35.0%	21	34.4%
Unemployed	105	65.2%	65	65.0%	40	65.6%
Children under 18 years old						
Yes	68	42.2%	41	41.0%	27	44.3%
No	93	57.8%	59	59.0%	34	55.7%
History of sexual victimization						
Yes	62	38.5%	53	53.0%	9	14.8%
No	99	61.5%	47	47.0%	52	85.2%
Religion						
Protestant Christian	51	31.9%	33	33.3%	18	29.5%
Catholic	23	14.4%	17	17.2%	6	9.8%
Buddhist	23	14.4%	0	0%	23	37.7%
Others	38	23.8%	35	35.4%	3	4.9%
Non-religion	25	15.6%	14	14.1%	11	18.0%
Religiosity	Mean = 2.09		Mean = 2.03		Mean = 2.19	
Last abuse episode						
One month ago	76	47.2%	58	58.0%	18	29.5%
Two month ago	19	11.8%	13	13.0%	6	9.8%
Three month ago	15	9.3%	7	7.0%	8	13.1%
Four month ago	5	3.1%	3	3.0%	2	3.3%
Five month ago	9	5.6%	5	5.0%	4	6.6%
Six month or over	37	23.0%	14	14.0%	23	37.7%
Length of abusive relationship	Mean = 68 months		Mean = 61 months		Mean = 80 months	
Marital Status						
Married-living together	36	22.6%	3	3.0%	33	55.0%
Married-separated	45	28.3%	30	30.3%	15	25.0%
Divorced	26	16.4%	19	19.2%	7	11.7%

[2] Level of acculturation was measured by a questionnaire which is 5-item measure scored on a 5-point scale measuring language preferred, food preferences, identifying oneself as Asian or American, etc. Higher scores indicate higher levels of acculturation.

Never married-living Together	29	18.2%	28	28.3%	1	1.7%
Never married-separated	19	11.9%	19	19.2%	0	0%
Others	4	2.5%	0	0%	4	6.7%
Highest degree of education						
Less than high school	28	17.4%	13	13.0%	15	24.6%
High school diploma or GED	49	30.4%	35	35.0%	14	23.0%
Some college	54	33.5%	39	39.0%	15	24.6%
Bachelor's degree	26	16.1%	12	12.0%	14	23.0%
Master's or higher	4	2.5%	1	1.0%	3	4.9%
Family income						
Under $ 10,000	91	57.6%	65	67.0%	26	42.6%
$ 10,000 – 19,999	21	13.3%	11	11.3%	10	16.4%
$ 20,000 – 29,999	18	11.4%	8	8.2%	10	16.4%
$ 30,000 – 39,999	13	8.2%	7	7.2%	6	9.8%
$ Over 40,000	15	9.5%	6	6.2%	9	14.8%
Age	Mean = 37.59		Mean = 37.70		Mean = 37.41	
Level of acculturation					Mean = 2.19	

2. Ethnic Group Differences on Demographic Variables

Logistic regression analyses were conducted to assess whether demographic variables can predict ethic group membership, Asian versus Caucasian. Living with children under 18 years old, employment, college degree, last abuse episode, family income, marital status, religiosity, age, living at shelter, history of sexual abuse, and length of abusive relationship were considered covariates. The results indicate that the covariates can predict Asian versus Caucasian with a high accuracy, which means that the two groups differ on several background characteristics. The test of the full model with the 11 predictors was statistically significant; $\chi^2(11) = 112.982$, $p < .001$. The model correctly predicted 90.4% of the cases. The Nagelkerke pseudo R^2 and Cox and Snell pseudo R^2 were .73 and .54 respectively. As a further measure of goodness of fit, the model produced a non-significant Hosmer and Lemeshow Test, $\chi^2(8) = 9.40$, $p = .310$.

Compared with Asians, Caucasians were more likely to be employed (OR =.06, CI =.01-.38), less likely to be currently in a marriage relationship with an abusive partner (OR =10.35, CI =2.65-40.38), more likely to have a history of sexual abuse during childhood and adolescence (OR = .13, CI = .04-.48), and more likely to live currently at a shelter (OR =.01, CI =.002-.09). No differences were found for the following variables: living with children under 18 years old, college degree, last abuse episode, family income, religiosity, age, and length of abusive relationship with abusive partner. Table 5.3 presents the results from logistic regression analysis.

Table 5.3 Logistic Regression Predicting Ethnic Group

Variables	B	SE	Wald	Odd Ratio (OR)	95% CI for OR
Living with children	-.39	.66	.342	.68	.19-2.49
Employment	-2.76	.92	9.11	.06**	.01-.38
College degree	.03	.78	.001	1.03	.22-4.77
Last abuse episode	.15	.14	1.15	1.17	.88-1.55
Family income	.19	.23	.68	1.21	.77-1.90
Marital status	2.34	.70	11.32	10.35**	2.65-40.38
Religiosity	.56	.33	2.83	1.75	.91-3.35
Age	-.014	.04	.15	.99	.92-1.06
Currently living at shelter	-4.35	.97	20.30	.01***	.002-.09
History of sexual abuse	-2.05	.67	9.30	.13**	.04-.48
Length of relationship with abusive partner	-.01	.004	2.67	.99	.99-1.00

Note: * $p < .05$; ** $p < .01$; *** $p < .001$

3. The Effect of Demographic Variables on Dependent Variables

Based on the previous studies, several demographic variables were tested in order to determine if these variables are significant factors influencing victims' psychological outcomes in this present study. The Pearson's correlations between dependent variables and two continuous demographic variables, which include length of relationship with an abusive partner and religiosity, were tested. For the dichotomous variables of history of sexual abuse, living at shelter, living with children, and employment, point serial correlations were examined. There was no pattern of high correlations, which suggests that the covariates were not strongly related to the outcomes. There is only moderate association between living at a shelter and psychological outcomes for the Caucasian sample. However, since there are a very small number of Asian shelter residents in this study, and dichotomous measurement is a cause of violation of multivariate normality assumption of SEM, the researcher decided not to enter this variable as a control variable in the SEM model.

4. Descriptive Statistics of the Observed Variables

Although depression and PTSD are treated as subsets of construct variable of psychological outcome in this study, this section provides information on the prevalence of depression and PTSD among the sample of abused women. Using the Radolff (1977) criterion (16 or above), 88.8% of the participants could be considered as having depressive symptoms. For the Asian group, almost all participants (96.5%) fulfilled the criteria. For the Caucasian group, 84% met the criteria. Also, there is a high prevalence of

PTSD among abused women (62.1%). Using Weathers et al.'s (1993) criterion (50 or above), 66.7% of the Asian group could be considered as having a diagnosis of PTSD as compared to 59.6% of the Caucasian group. In both groups, PTSD and depression were highly correlated ($r = .782$, $p<.001$ for Caucasians; $r = .687$, $p <.001$ for Asians). Table 5.4 presents the prevalence of depression and PTSD among abused women.

Table 5.4 Prevalence of Depression and PTSD Using Clinical Cut-Off Point

Cut-off point	All		Caucasians		Asians	
	N	%	N	%	N	%
CES-D						
16 or greater	135	88.8%	70	84.2%	55	96.5%
Less than 16	17	11.2%	15	15.8%	2	3.5%
PCL-C						
50 or greater	95	62.1%	59	59.6%	36	66.7%
Less than 50	58	37.9%	40	40.4%	18	33.3%

Note: CES-D: depression scale ; cut-off point of 16 to identify those with a high likelihood for diagnosis of depression (Radloff, 1977); PCL-C: PTSD scale; cut-off point of 50 to identify those with a high likelihood for diagnosis of PTSD (Weathers et al., 1993).

Table 5.5 presents the means and standard deviations for 14 observed variables used in this study. A series of t-tests were computed to determine whether ethnic groups differ significantly on 14 observed variables. To control for type I error, the alpha was set at .004 (.05 divided by 14). A significant difference was found between Caucasian and Asian women on the 8 observed variables. Compared to Asian women, Caucasian women experienced higher levels of partner violence during the past year, which include psychological aggression, physical assault, sexual coercion, and injuries. In this sample, Asians were more likely to perceive informational and tangible support than Caucasians.

Asians were more likely to engage in seeking support than Caucasians. Asians were less likely to engage in avoidant coping skills than Caucasians. Regarding adverse psychological outcomes, the level of symptoms for Asians was slightly higher than for Caucasians, but there was no statistically significant difference.

Table 5.5 Mean and Standard Deviation of Observed Variables

	All		Caucasians		Asians		Initial Comparison
	M	SD	M	SD	M	SD	t-value
Psychological Outcomes							
PTSD	3.22	.92	3.14	.98	3.35	.80	-1.55
Depression	1.69	.65	1.63	.71	1.78	.52	-1.49
Violence							
Psychological Aggression	13.24	7.27	14.77	7.36	10.73	6.43	3.52**
Physical Assault	6.75	6.87	8.67	7.47	3.60	4.21	5.51**
Sexual Coercion	5.61	6.75	6.78	7.12	3.70	5.67	3.04**
Injuries	4.67	5.54	6.12	5.96	2.29	3.73	5.01**
Perceived Social Support							
Informational	2.71	.86	2.53	.88	3.00	.74	-3.67**
Tangible	2.25	.86	2.06	.84	2.55	.81	-3.62**
Emotional	2.59	.85	2.49	.88	2.76	.80	-1.99
Active Coping							
Problem Focus	1.89	.49	1.82	.50	1.99	.46	-2.20
Seeking Support	1.57	.81	1.37	.82	1.90	.69	-4.12**
Passive Coping							
Blamed Self	1.92	.81	2.03	.82	1.73	.78	2.26
Avoidance	1.95	.59	2.09	.55	1.71	.57	4.21**
Wishful Thinking	2.34	.58	2.44	.57	2.17	.57	2.83

Note: To control type I error, the alpha was set at .004 (.05 divided by 14).
** $p < .004$; ** $p < .001$

II. Structural Equation Modeling Analysis

This section consists of two parts: data preparation and structural equation modeling (SEM) analysis. In data preparation, the assumption test is discussed. In the SEM analysis part, confirmatory factor analysis (specifies the relationship of the latent to the observed variables) was first analyzed before subsequent analysis of the structural model (specifies the relationships among latent variables). And then, multi-group analysis was conducted to determine if Caucasian and Asian women differ on any of the model parameters. AMOS 5.0 was used for all modeling analyses.

1. Data Preparation

1.1. Missing variables

Since SEM models are based on the promise that the covariance matrix follows a Wishart distribution (Brown, 1994), complete data are required for the probability density. In meeting this requirement, listwise deletion of missing data was employed. Among a total of 161 cases, two cases with missing values were deleted and computations were based only on those cases with values on all variables. As a result of this screening, the total sample size was identified as 159.

1.2. Sample size

There were a total of 24 parameters (excluding error variance) to be estimated in the hypothesized model including indicator variables for the latent variables, the 9 structural paths among the predictor and dependent variables, and one covariance

between active coping and passive coping. Based on Bentler and Chou's (1987) 5 to10 subjects per estimated parameter rule, a total of 120 (minimum of 5 subjects per parameter) to 240 (maximum of 10 subjects per parameter) sample participants were considered reasonable. With five subjects per parameter, the maximum number of subjects required would be 120 (24 times 5). The actual sample size was 159, which meets the minimum requirement for adequate statistical power as well as for yielding meaningful results. However, in multi-group analysis, sample size was not adequate, which resulted in low power.

1.3. Normality

To determine the extent and shape of non-normality distributed data, the measured variables were screened for skewness and kurtosis. The acceptable range for normality is sknewness lying between -1.96 to 1.96 (Hair, Anderson, Tathan, & Black, 1998). Likewise, acceptable range for normality is kurtosis lying between -1.96 to 1.96 at .05 error level (Hair et al., 1998). All skewness and kurtosis statistics fall between critical values. The smallest skewness value was -1.02 and the largest value was 1.48. The smallest kurtosis value was -1.11 and the largest value was 1.75. The data reflect a relatively normal distribution and were appropriate for the analyses.

1.4. Outliers

Outliers were detected using histograms and box plots. Although several outliers were found, the researcher determined to leave them in the analysis because the outliers

were not due to recording error or error in instrument administration. Cook's distance was also examined to detect outliers. Cook's distance greater than one would indicate that the data should be examined further (Stevens, 1996). The maximum value of Cook's in the sample data was .95, under the threshold of one and as such the results indicated that the data met assumption.

1.5. Linearity

Scatter plots of the independent and dependent variables were examined to assess the assumption of linearity. There was no evidence showing non-linear or curvilinear relationships.

1.6. Scale reliability

The internal consistency coefficients for the measures were calculated. An alpha coefficient equal to or greater than .70 was established as a minimum acceptable value for adequate scale reliability (Robinson, Shaver, & Wrightsman, 1991). Table 5.6 shows that the alpha coefficient of most scales in this study ranged from .70 to .96, which demonstrated acceptable internal consistency.

Table 5.6 Cronbach Alpha Coefficients for the Observed Variables

Instruments	Subscales	All	Caucasians	Asians
		α	α	α
CTS 2[a]		.95	.96	.90
CTSPSY	Psychological Aggression	.86	.88	.80
CTSPHY	Physical Assault	.94	.94	.88
CTSSEX	Sexual Coercion	.89	.89	.86
CTSINJ	Injuries	.84	.83	.79
***PCL-C[b]**		.93	.94	.91
PCLLINT	Intrusion	.86	.85	.87
PCLAVO	Avoidance	.85	.88	.75
PCLARO	Arousal	.82	.82	.83
***CES-D[c]**		.92	.93	.86
CESDEP	Depressive Affective	.85	.88	.78
CESWELL	Well-Being	.80	.84	.67
CESSOMA	Somatic	.77	.82	.63
CESINTER	Interpersonal	.73	.75	.70
PSS[d]		.90	.90	.88
PSSINF	Informational Support	.80	.81	.72
PSSTAN	Tangible Support	.81	.81	.76
PSSEMO	Emotional Support	.78	.78	.79
WCCL –AC[e]		.86	.86	.83
ACPF	Problem Focused Coping	.78	.78	.74
ACSS	Seeking Social Support	.85	.84	.80
WCCL –PC[f]		.87	.87	.85
PCBS	Blamed Self	.70	.70	.67
PCAV	Avoidance	.75	.73	.75
PCWT	Wishful Thinking	.77	.78	.74

Note 1: CTS 2[a]: The Revised Conflict Tactic Scale; PCL-C[b]: PTSD Checklist; CES-D[c]: Center for Epidemiologic Studies- Depressed Mood Scale; PSS[d]: Perceived Social Support; WCCL –AC[e]: The Revised Ways of Coping Checklist -Active Coping; WCCL –PS[f]: The Revised Ways of Coping Checklist -Passive Coping.
Note 2: * In SEM analysis, since PTSD and depression are considered subsets of a construct variable of psychological outcome, global means of CES-D and PCL-C were used.

1.7. Muticollinarity

To identify multicollinearity, tolerance value was used. The lower the tolerance value, the higher the degree of multicollinearity. In this sample, the smallest tolerance

value reported was .294, which is well above the recommended cutoff threshold of .10 (Hall, et al., 1998). Also, the variance inflation factor (VIF) was used to detect multicollinearity. The larger the VIF, the higher the degree of multicollinearity among the independent variables. The cutoff threshold for indicating multicollinearity is a VIF value above 10. The largest VIF was 3.398. In addition, Pearson correlation coefficients were used to detect multicollinearity. Less than .70 was established to determine whether subscales for different instruments measured relatively independent constructs. There was no evidence of multicollinearity (Table 5.7).

Table 5.7 Correlation Matrix for Observed Variables

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. CTSPSY	1.00													
2. CTSPHY	.655**	1.00												
3. CTSSEX	.501**	.519**	1.00											
4. CTSINJ	.569**	.772**	.638**	1.00										
5. PSSINF	-.106	-.245**	-.127	-.300**	1.00									
6. PSSTAN	-.146	-.158*	-.101	-.234**	.676**	1.00								
7. PSSEMO	-.070	-.262**	-.093	-.303**	.687**	.624**	1.00							
8. ACPF	.052	.004	-.078	.022	.220**	.133	.209**	1.00						
9. ACSS	-.125	-.155	-.096	-.133	.431**	.269**	.374**	.595**	1.00					
10. PCBS	.219**	.226**	.218**	.252**	-.128	-.201**	-.134	.107	-.055	1.00				
11. PCAV	.378**	.325**	.317**	.387**	-.234**	-.275**	-.252**	.057	-.257**	.579**	1.00			
12. PCWT	.265**	.223**	.266**	.303**	-.126	-.148	-.132	.159*	-.136	.402**	.643**	1.00		
13. PCL-C	.315**	.266**	.273**	.310**	-.265**	-.293**	-.271**	.039	-.057	.378**	.327**	.266**	1.00	
14. CES-D	.147	.130	.168*	.167*	-.354**	-.299**	-.311**	-.108	-.171*	.314**	.328**	.227**	.678**	1.00

Note 1: * significant at .05, ** significant at .01

Note 2: CTSPSY = Psychological Aggression; CTSPHY = Physical Assault; CTSSEX = Sexual Coercion; CTSINJ = Injuries; PSSINF = Informational Support; PSSTAN = Tangible Support; PSSEMO = Emotional Support; ACPF = Problem Focused Coping; ACSS = Seeking Social Support; PCBS = Blame Self; PCAV = Avoidance; PCWT = Wishful Thinking; PCL-C: PTSD; CES-D = Depression

2. Model Fit Indexes

While there are various indexes measuring model fit in SEM, this study reports four of the most popular measures: the Chi-Square value, the Goodness-of-Fit Index (GFI), the Comparative Fit Index (CFI), and the Root Mean Square Error of Approximation (RMSEA). The conventional chi-square statistic is traditionally reported in an analysis of latent structures as a means to test the closeness of fit between the sample covariance matrix (S) and the implied covariance matrix $\Sigma(\theta)$ (Hu & Bentler, 1995). When examining the chi square statistic for model fit, models that have a better overall fit typically have low values reflecting smaller differences between a predicted covariance matrix based on the model and the sample covariance matrix. Therefore, smaller chi-square values indicate a better fit, and a nonsignificant chi square is desired (Bollen, 1989; Hu & Bentler, 1995). However, chi square values are dependent upon sample size. Ulman (2001) suggested dividing the chi square value by the degrees of freedom. If the resulting ratio is less than 2, it is a good fitting model.

GFI indicates the relative amount of the observed variances and covariances accounted for by a model (Joreskog & Sorbom, 1982; Tranaka & Huba, 1985). CFI indicates the relative reduction in lack of fit as estimated by the noncentral chi-square of a target model versus a baseline model (Bentler, 1990). Values for the GFI and CFI range from 0 to 1 with higher values indicating a better fitting model. A conventional rule of evaluating GFI and CFI is to use .90 as a cut off value (Bentler & Bonett, 1980). The value of .95 or above is usually associated with models that are plausible approximations of the data (Raykov & Marcoulides, 2000). A relatively modern approach to model fit is to accept that models are only approximations, and that a perfect fit may be too much to

ask for. Instead, the problem is to assess how well a given model approximates the true model. This view led to the development of an index called RMSEA (Root Mean Square Error of Approximation) (Hox & Bechger, 1998). If the approximation is good, the RMSEA should be small. Typically, values for RMSEA less than .05 are indicative of a very good model; an index of .05 to .08 is indicative of a reasonably good fit; values of more than .10 are considered a poor fit (Loehlin, 1998). Both the CFI and RMSEA are sensitive to model misspecification and are minimally affected by sample size (Hu & Bentler, 1995) Table 5.8 shows a conventional rule for evaluation of fit indices.

Table 5.8 Conventional Rule for Evaluation of Fit Indexes

Criteria	Chi-Square	GFI	CFI	RMSEA
Good fit	Non significance desirable	Greater than .95	Greater than .95	Less than .05
Acceptable	& χ^2/df < 2 acceptable	Greater than .90	Greater than .90	Greater than .05 up to .08
Poor fit		Less than .90	Less than .90	.10 and higher

3. Measurement Model Test through Confirmatory Factor Analysis

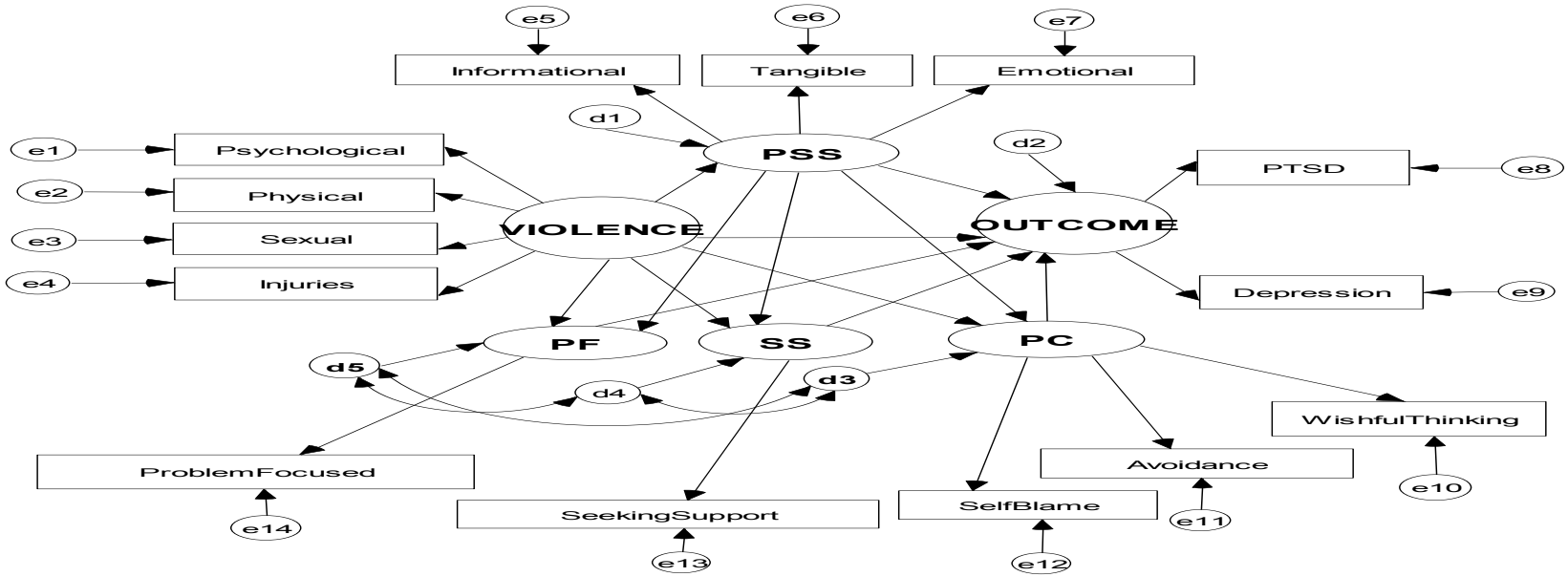
In general, it is recommended to test the measurement model through confirmatory factor analysis in order to insure adequate measurement and then test the full model with structural pathways. The confirmatory factor analysis was used to determine whether the manifest indicators were valid measures of the latent constructs. This analysis provided measures of the overall fit of the model plus the estimated three types of parameters: factor loadings linking latent variables with their indicators,

measurement error variances for the indicators, and a squared multiple correlations (SMC; communalities of the variables).

The measure fit statistics in this study yielded a Chi-square value of 107.348, with a 67 degree of freedom and a probability of .001, thereby suggesting that the fit of the data to the hypothesized measurement model is less than adequate. However, since the chi-square test is hypersensitive to sample size, the researcher also used the criteria of $\chi^2/df < 2$. In this study, $\chi^2/df = 1.60$ indicated adequate fit. Additional goodness-of-fit indices for the measurement model were examined. The GFI and the CFI values are .916 and .960. The value of RMSEA is .062, suggesting adequate fit.

Estimates of the parameters, i.e. the factor loading, the variances and covariances of the factor, were examined. While most observed variables loaded significantly on their respective constructs, the problem-focused coping loading was relatively weak (.421). In addition, there was an error message indicating negative error variance in the observed variable of seeking support. Since there is no admissible solution identified, the researcher determined to consider this variable a separate factor rather than a subset of the latent variable of active coping. Figure 5.1 shows the alternative model based on the measurement model test.

Figure 5.1 Alternative Model



Note: Violence: Level of Domestic Violence; PSS: Perceived Social Support; PF: Problem-Focused Coping; SS: Seeking Support Coping; PC: Passive Coping; Outcome: Psychological Outcome

4. Alternative Measurement Model Test through Confirmatory Factor Analysis

Treating seeking support and problem-focused coping as a separate construct rather than subsets of the construct of active coping, an alternative model was tested. In the case where latent variables were represented by a single indicator, the factor loading was estimated by the square root of its coefficient alpha reliability and the error variance was set to equal one minus the reliability multiplied by the variance ({1-relaiility} * variance) (Ping, 2003). The measure fit statistics in this study yielded a chi-square value of 70.55, with 48 degree of freedom and a probability of .019, thereby suggesting that the fit of the data to the alternative measurement model is less than adequate. However, χ^2/df = 1.47 is less than 2 indicating an adequate fit. Additional goodness-of-fit indices for the hypothesized model were examined. The GFI and the CFI values are .935 and .975. The value of RMSEA is .055, suggesting adequate fit.

The relations of the observed measures to their posited underlying constructs were significant and in the expected directions. Table 5.9 represents factor loadings of each observed variable to latent variables, error variance, and proportions of explained variance (SMC or R^2). Using Tabachnick and Fidell's (1996) criteria for interpretation of factors, the following can act as a rule of thumb for determining the adequacy of factor loadings: loadings in excess of .71 are considered excellent, .63 are considered very good, .55 are considered good, .45 are considered fair, and .32 poor. For the subscales of violence, standardized factor loadings ranged from .68 to .90. For the subscales of psychological outcomes, factor loadings ranged from .84 to .91. The other two subscales show factor loadings with perceived social support ranging from .79 to .86 and passive coping from .62 to .94.

SMC (R^2) shows the portion of variance in the variable that is accounted for by the factor. Approximately 80% of variance of injuries is shared with violence, while 49% of psychological aggression, 74% of physical assault, and 46% of sexual coercion with violence. Seventy four percent of variance of informational support is shared with perceived social support, while 62% of tangible support and 64% of emotional support with perceived social support. Approximately 38% of variance of self-blame is shared with passive coping, while 88% of avoidance and 46% of wishful thinking with passive coping. Approximately 82% of variance of PTSD is shared with psychological outcome, while 70% of variance of depression is shared with psychological outcome.

Table 5.9 Factor Loadings, Error Variance, and SMC (R^2)

Observed Variables	Factor loadings [a]	Error Variance [b]	SMC(R^2)
Level of Domestic Violence (VIOLENCE)			
→ Psychological Aggression	.70[nt]	26.76***	.49
→ Physical Assault	.86***	12.25***	.74
→ Sexual Coercion	.68***	24.86***	.46
→ Injuries	.90***	6.23***	.80
Perceived Social Support (PSS)			
→ Informational	.86[nt]	.19***	.74
→ Tangible	.79***	.28***	.62
→ Emotional	.80***	.26***	.64
Passive Coping (PC)			
→ Wishful Thinking	.68[nt]	.18***	.46
→ Self Blame	.62***	.41***	.38
→ Avoidance	.94***	.04 [ns]	.88
Psychological Outcome (OUTCOME)			
→ PTSD	.91[nt]	.15 [ns]	.82
→ Depression	.84***	.13***	.70

Note: a: Standardized coefficient; b: Unstandardized coefficient; *** p<.001;
nt means not tested for significance because this loading was fixed to 1.00 to scale a factor

5. Combined Model Test

5.1. Model fit

Following confirmatory factor analysis, full model, which includes a measurement model and structural model, was tested. This model is a combined model which considers two ethnic groups a single group. In SEM, the null hypothesis is that there is a good fit between the hypothesized model and the sample data. The test of the hypothesis and the sample data yielded a chi-square value of 97.72, with 64 degree of freedom and a probability of .004, thereby suggesting that the fit of the data to the hypothesized model is less than adequate. However, since the chi-square test is hypersensitive to sample size, the researcher used Ulman's (2001) suggestion dividing the chi square value by the degrees of freedom. In the present study, $\chi^2/df = 1.527$ is less than 2 indicating an adequate fit. Additional goodness-of-fit indices for the hypothesized model were examined. The GFI and the CFI values were .924 and .967. The value of RMSEA is .058, suggesting adequate fit. The results of fit indices are presented in table 5.10.

In sum, an examination of collection of fit indices suggested a mixed support for the hypothesized model ranging from not adequate to good fitting with the sample data in the present study. Although the GFI (.924) suggests that model fit was a reasonably good fit, the CFI (.967) suggests that it is well-fitting. In addition, the RMSEA value of .058 is well within the recommended range of acceptability (.05 to .08).

Table 5.10 Model Fit Statistics in the Alternative Model

Fit Indices	Values	Qualitative Description
Degree of Freedom	64	
Chi-Square	97.72	Not adequate
P	P =.004	
Chi-Square/df	1.527	Adequate
Goodness of Fit Index (GFI)	.924	Acceptable
Comparative Fit Index (CFI)	.967	Good fit
Root Mean Square Error of Approximation (RMSEA)	.058	Reasonably good fit

5.2. Structural path

Structural path coefficients are presented in table 5.11. Unstandarized estimates are interpreted as regression coefficients (B) that estimate the direct effect of predictors on criterion variables. In other words, unstandarized estimates are coefficients that indicate the expected change in a criterion given a 1 point increase in the predictor, when controlling for the other variables in the model (Kline, 1998). Standardized path coefficients are interpreted as correlations, or as beta regression coefficients (β), and their squared multiple correlation (SMC) as proportions of explained variance (R^2). Standardized path coefficients with absolute values less than .10 may indicate a "small" effect, values around .30 a "medium" effect, and those greater than .50 a "large" effect or relation between variables (Kline, 1998). Path coefficients are tested for significance using Critical Ratios (CR). A CR of greater than ± 1.96 is considered to be statistically significant at the .05 level. To test mediational hypotheses, the researcher used Baron and Kenny's (1986) criteria for mediation: a) the independent variable must be associated with the hypothesized mediator, b) the mediator must be associated with the dependent

variable, and c) when the mediator is statistically controlled, a previous significant association between independent variable and dependent variable must no longer be significant or must be reduced significantly in effect size.

In the model of this study, level of violence had no direct effect on psychological outcomes (β =.10, p >.05). Although there was no direct effect of level of violence on psychological outcomes, there was indirect effect of level of violence on psychological outcomes through passive coping and perceived social support. Level of violence had a direct effect on perceived social support (β =-.32, p <.001) and perceived social support was found to be a significant predictor of psychological outcomes (β = -.35, p =.001). Level of violence had a direct effect on passive coping (β =.40, p < .001), and passive coping was found to be significantly related to psychological outcomes (β =.40, p < .001). There was no significant relationship between level of violence and problem focused coping (β =.11, p >.05) and between level of violence and seeking support (β = -.02, p >.05). There was no significant relationship between problem-focused coping and psychological outcomes (β =-.19, p >.05) and between seeking support and psychological outcomes (β = .33, p >.05). Perceived social support had a direct effect on problem focused coping (β =.30, p =.003) and seeking support (β =.49, p < .001). Perceived social support also had a direct effect on passive coping (β =-.18, p=.04). The relationships among model variables, and factor loadings of observed variables on latent constructs are shown in Figure 4.2.

Table 5.12 presents squared multiple correlations (SMC), which is printed above the latent constructs in Figure 4.3. The SMC value represents the proportion of variance (R^2) that is explained by the predictors of the construct in question. Thirty- one percent of

the total variance in psychological outcomes is accounted for by its five predictors: level of violence, perceived social support, problem-focused coping, seeking support and passive coping. Ten percent of the total variance in perceived social support is accounted for by level of violence. Twenty-four percent of the total variance in seeking support is accounted for by its two predictors: level of violence and perceived social support. Only 8% of the total variance in problem-focused coping is accounted for by its two predictors: level of violence and perceived social support. Twenty four percent of the total variance in passive coping is accounted for by its two predictors: level of violence and perceived social support.

Table 5.11 Structural Path Coefficients of the Model

Structural Path	B	β	CR	P
Level of Domestic Violence (VIOLENCE)				
→ Psychological Outcomes	.02	.10	1.08	ns
→ Perceived Social Support	-.05	-.32	-3.53	***
→ Problem Focused Coping	.01	.11	1.10	ns
→ Seeking Social Support	-.003	-.02	-.20	ns
→ Passive Coping	.03	.40	4.02	***
Perceived Social Support (PSS)				
→ Psychological Outcomes	-.39	-.35	-3.27	.001
→ Problem Focused Coping	.20	.30	2.98	.003
→ Seeking Support	.53	.49	5.20	***
→ Passive Coping	-.10	-.18	-2.01	.044
Problem Focused Coping (PF)				
→ Psychological Outcomes	-.32	-.19	-1.06	ns
Seeking Support (SS)				
→ Psychological Outcomes	.34	.32	1.67	ns
Passive Coping (PC)				
→ Psychological Outcomes	.84	.40	3.31	***

Note: *** $p < .001$

Table 5.12 Squared Multiple Correlations (SMC) of the Model

Latent Variables	SMC
Perceived Social Support (PSS)	.10
Problem Focused Coping (PF)	.08
Seeking Social Support (SS)	.24
Passive Coping (PC)	.24
Psychological Outcomes (OUTCOME)	.31

5.3. Modification index

Modification index is considered one useful aid in assessing the fit of a specific model. Although modification index can be useful in assessing the impact of theoretically based model modification, they should only be used (with the largest modification index) if that parameter can be interpreted substantively (Hair et al., 1998). In other words, model modification must have a theoretical justification before being considered. In this study, MI values are not substantial, which suggested that adding a path would not significantly reduce the chi-square value. In addition, there is a lack of theoretical justification considering them. The researcher, therefore, decided not to revise this model. Tables 5.13 and 5.14 present modification index.

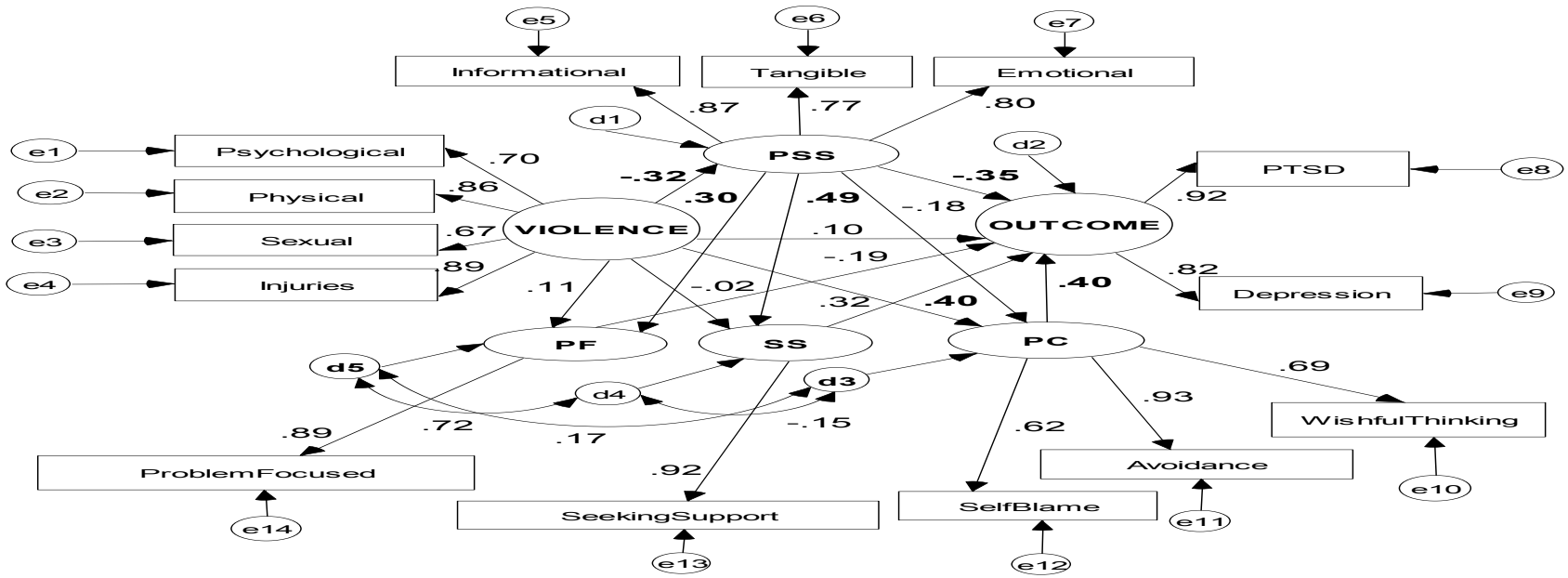
Table 5.13 Regression Weight Modification Index

Pathways	MI	Par Change
Depression ← VIOLENCE	4.667	-.015
Depression ← SS	5.972	-.106
Depression ← PF	7.655	-.205
Depression ← Seeking Support	4.876	-.090
Depression ← Physical Assault	4.122	-.010
Depression ← Injuries	4.322	-.013
Depression ← Psychological Aggression	5.142	-.010
Depression ← Informational Support	4.642	-.084
Depression ← Problem Focused Coping	6.934	-.180
PTSD ← SS	4.487	.127
PTSD ← PF	5.752	.245
PTSD ← Psychological Aggression	7.022	.017
PTSD ← Problem Focused Coping	5.210	.215
Psychological Aggression ← Emotional Support	5.305	1.173

Table 5.14 Covariance Modification Index

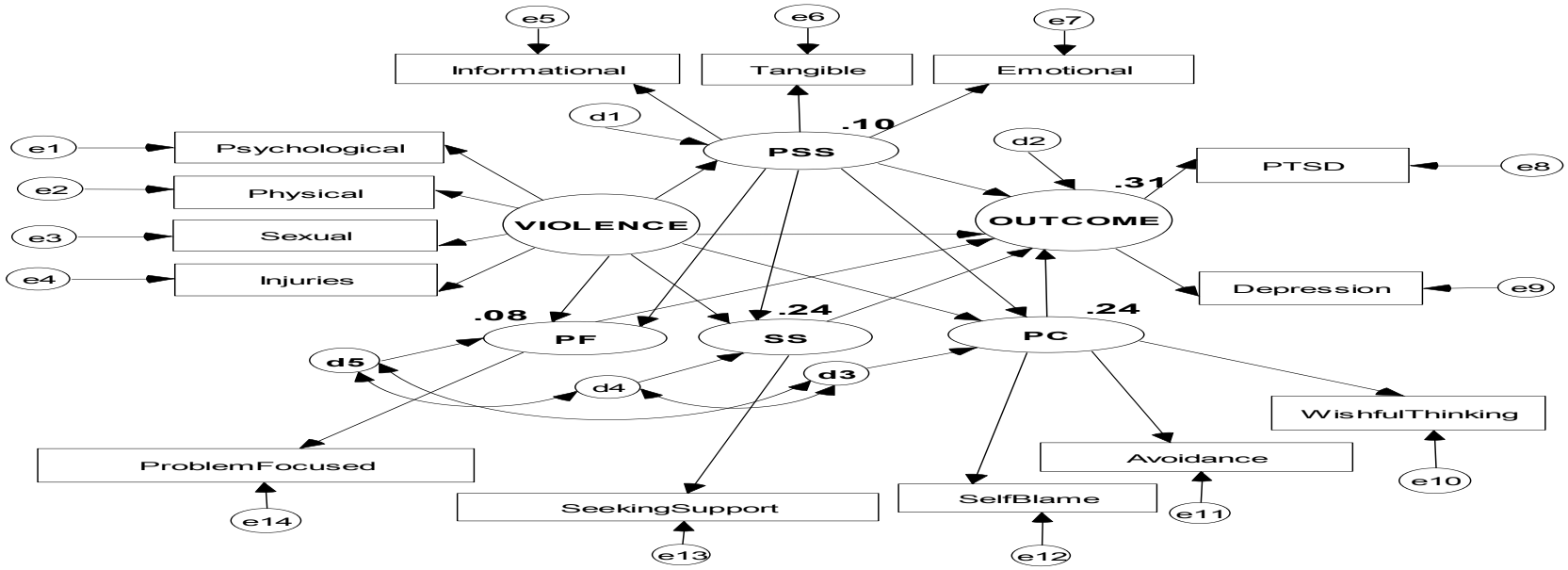
Covariance	MI	Par Change
e3 ↔ d5	6.093	-.434
e3 ↔ e2	5.884	-4.087
e9 ↔ d1	6.872	-.067
e1 ↔ e2	5.450	4.093
e1 ↔ e4	7.919	-3.791
e8 ↔ d1	5.161	.080
e8 ↔ e1	4.301	.518
e7 ↔ e1	4.953	.560
e14 ↔ e3	5.411	-.362

Figure 5.2 Factor Loadings in Measurement Model and Path Coefficients in Structural Model



Note: Violence: Level of Domestic Violence; PSS: Perceived Social Support; Outcome: Psychological Outcome;
PF: Problem Focused Coping; SS: Seeking Support; PC: Passive Coping

Figure 5.3 Squared Multiple Correlations (SMC)



Note: Violence: Level of Domestic Violence; PSS: Perceived Social Support; Outcome: Psychological Outcome;
PF: Problem Focused Coping; SS: Seeking Support; PC: Passive Coping

6. Results of Hypotheses Testing

Hypothesis 1: Direct effect of the level of violence on psychological outcomes

This hypothesis was not supported by the data. There was no direct effect of violence on psychological outcomes ($\beta = .10$, $p>.05$) in this model, which controls the effects of perceived social support and coping.

Hypothesis 2: Direct effect of perceived social support on psychological outcomes

This hypothesis was supported by the data. Perceived social support had a direct effect on psychological outcomes, which is statistically significant ($\beta = -.32$, $p <.001$). Based on this result, women who perceive more social support exhibited lower levels of adverse psychological outcomes.

Hypothesis 3-1: Direct effect of problem-focused coping and seeking support coping on psychological outcomes

This hypothesis was not supported by the data. There was no significant relationship between problem-focused coping and psychological outcomes ($\beta = -.19$, $p>.05$). Similarly, there is no statistically significant relationship between seeking social support and psychological outcomes ($\beta = .33$, $p>.05$).

Hypothesis 3-2: Direct effect of passive coping on psychological outcomes.

This hypothesis was supported by the data. Passive coping had a direct effect on psychological outcomes, which is statistically significant ($\beta = .40$, $p <.001$). Based on this

result, women who were more likely to engage in passive coping showed higher levels of adverse psychological outcomes.

Hypothesis 4: Direct effect of perceived social support on coping

This hypothesis was supported by this study. Perceived social support had a direct effect on problem-focused coping ($\beta = .30$, $p = .003$) and seeking support ($\beta = .49$, $p = <.001$). Women who exhibited higher levels of perceived social support were more likely to engage in problem-focused coping and seeking support. In addition, perceived social support had a direct effect on passive coping ($\beta = -.180$, $p = <.05$). Women who exhibited higher levels of perceived social support were less likely to engage in passive coping.

Hypothesis 5: Mediating effect of perceived social support on the relationship between the level of violence and psychological outcomes

This hypothesis was supported by this study. Although there was no direct effect of violence on psychological outcomes, there was an indirect effect through mediator of perceived social support. The relationship between violence and psychological outcomes is said to be indirect if violence causes perceived social support which in turn causes psychological outcomes. The direct effect of violence on perceived social support was significant ($\beta = -.32$, $p < .001$). The direct effect of perceived social support on psychological outcomes was also significant ($\beta = -35$, $p = .001$). Adding perceived social support in the model reduced the influence of violence on psychological outcomes (β from .35, $p < .001$ to .24,

p <.01 when passive coping was entered; to .10, p >.05 when perceived social support and coping were entered).

Hypothesis 6-1: Mediating effect of problem-focused coping and seeking support on the relationship between level of violence and psychological outcome

This hypothesis was not supported by the data. There was no mediating effect of problem-focused coping and seeking social support on the relationship between level of violence and psychological outcomes.

Hypothesis 6-2: Mediating effect of passive coping on the relationship between level of violence and psychological outcomes

This hypothesis was supported by this study. Although there was no direct effect of violence on psychological outcomes, there was an indirect effect through mediator of passive coping. The relationship between violence and psychological outcomes is said to be indirect if violence causes passive coping which in turn causes psychological outcomes. The direct effect of violence on passive coping was significant (β =.40, p<.001). The direct effect of passive coping on psychological outcomes was also significant (β = .40, p <.001). Adding passive coping in the model reduced the influence of level of violence on psychological outcomes (β from .35, p<.001 to .19, p <.05 when passive coping was entered; to .10, p >.05 when perceived social support and copings were entered).

7. Multi-Group Analysis

7.1. Model fit change

Multi-group analyses were conducted on the model to evaluate cross-group invariance across ethnicity. Although the most comprehensive comparisons for multi-group analysis was to impose ethnicity equality constraints on factor loadings, structural coefficients, structural covariance, structure residual, and measurement residual, the present study focused on cross-group constraints related to the present study's hypotheses which include invariance in the measurement model and structural model. In general, the main question of a multi-group analysis is to examine whether or not components of the measurement model and/or the structural models are invariant across groups (Byrne, 2001). For this study, a series of nested models was formed by cumulatively imposing cross-ethnicity equality constraints on factor loadings and structural parameters. The evaluation of invariance involves the comparison of the relative fits of models: one with cross-group equality constraints imposed on its parameters, and the other without constraints. If the fit of the model with equality constraints is not significantly different from that of the unconstrained model, indicated by a nonsignificant $\chi^2_{difference}$ test ($\Delta\chi^2$), the models do not differ significantly across groups.

First, the Caucasian model and Asian model were tested simultaneously with none of the parameters across samples constrained to be equal, and the test yielded χ^2 (128) = 151.652, p =.075; χ^2 /df = 1.185. This unconstrained model served as the baseline. Second, equality was imposed for factor loadings, which yielded χ^2 (136) = 163.336, p =.055; χ^2 /df = 1.201. A comparison of this model and the baseline model yielded a difference in χ^2 value ($\Delta\chi^2$) of 11.683 with 8 degree of freedom, which was not statistically significant at .05 level (p =.166),

which means that there was no statistically significant decline in model fit when comparing the restricted model with the baseline model. This result indicates that the measurement parameters as a set did not differ significantly across the Caucasian and Asian participants. Since the assumption of invariance factor loadings across groups was not rejected in this study, equality was imposed on the structural parameters without releasing constraints for measurements. The overall test of this model yielded χ^2 (148) = 184.256, p =.023; χ^2 /df = 1.245 (Model 2). A comparison of this model and the less constrained model (equality imposed for factor loadings only) yielded difference in χ^2 value ($\Delta\chi^2$) of 20.870 with 12 degree of freedom, which was not statistically significant at .05 level (p =.052). It means that structure parameters as a set do not differ significantly across the Caucasian and Asian participants. However, such a conclusion should be viewed cautiously, since this test was conducted with a small sample size for the Asian group, which strongly influences the p-value of a test. In addition, the probability value of .052 is slightly above the cut-off of .05. Additional analysis was conducted to determine if any specific parameters differ between groups. The test result revealed that allowing groups to have unique estimates of the degree of association between violence and psychological outcome reduced the $\Delta\chi^2$ by 7.103 (df = 1, p =.008). Removing other parameter constraints did not improve the model fit. Table 5.15 presents the chi-square change results for multi-group comparison.

Contrary to the separate group analysis, the multi-group analysis showed no difference between two groups on the measurement model and on the structural model except only single difference in the structural model, which included a path indicating direct effect of violence on psychological outcome. This difference was also found in the separate group

analysis. Therefore, it is the most confident to conclude that the direct path from violence to outcome between groups does differ. The other difference in structural parameters between two groups should be evaluated by more cautiously. Because the sample size of Asians is so small (N=60), the analyses possessed reduced power to statistically test the plausibility of imposing equality constraints across groups. Given the small sample size of the Asian group, the differences which were found in the separate group analysis may be most interpretable. In other words, in this study the criteria for respecification were not limited to the statistically fit, but also included substantive meaningfulness. In this way, SEM was used in a more exploratory way. A visual inspection of the standardized structural parameters revealed some differences between the groups.

Table 5.15 Chi-Square Change Results for Multi-Group Comparison

Model Comparison	$\Delta\chi^2$	Δ df	P*
Unconstrained model (Baseline model) vs. Measurement parameters constrained model (Model 1)	11.683	8	.166
Measurement parameters constrained model (Model 1) vs. Measurement and structural parameters constrained model minus constraint on the path from violence to outcome (Model 2)	13.767	11	.246
Measurement and structural parameters constrained model minus constraint on the path from violence to outcome (Model 2) vs. Measurement and structural parameters fully constrained Model (Model 3)	7.103	1	.008

Note: * χ^2 change significance test

7.2. Visual inspection of measurement and structural models of each group

Based on a separate group analysis, inspection of the measurement parameters shows that the two groups shared some characteristics in terms of direction, but also differed from each other in factor loading values. Table 5.16 presents factor loadings in the Caucasian and the Asian group. For both groups, the relations of the observed measures to their posited underlying constructs were significant and in the expected directions. However, the value of factor loading was different from one to another.

In the Caucasian sample, for the subscales of violence, factor loadings ranged from .68 to .90. In the Asian sample, for the subscales of violence, factor loadings ranged from .57 to .69. For the subscales of psychological outcomes, in the Caucasian sample, factor loadings ranged from .81 to .96, while factor loadings ranged from .78 to .89 in the Asian sample. The other two subscales show factor loadings with perceived social support ranging from .73 to .93 in the Caucasian group and 69 to .84 in the Asian group, and passive coping from 64 to 95 in the Caucasian group and 53 to 87 in the Asian group.

Although the relations of the observed measures to their posited underlying constructs were significant and in the expected directions in both groups, overall, indicators loaded more heavily on constructs for the Caucasian group than the Asian group.

Table 5.16 Factor Loadings in Measurement Model

	Caucasian			Asian		
	B	β	P	B	β	P
Level of Domestic Violence (VIOLENCE)						
→ Psychological Aggression	1.00	.72	*nt*	1.00	.59	*nt*
→ Physical Assault	1.26	.90	***	.69	.57	***
→ Sexual Coercion	.92	.68	***	.91	.60	***
→ Injuries	1.02	.90	***	.69	.69	***
Perceived Social Support (PSS)						
→ Informational	1.00	.93	*nt*	1.00	.69	*nt*
→ Tangible	.75	.73	***	1.31	.84	***
→ Emotional	.86	.81	***	1.18	.77	***
Passive Coping (PC)						
→ Wishful Thinking	1.00	.68	*nt*	1.00	.66	*nt*
→ Avoidance	1.35	.95	***	1.32	.87	***
→ Blamed Self	1.35	.64	***	1.10	.53	***
Psychological Outcome (OUTCOME)						
→ PTSD	1.00	.96	*nt*	1.00	.89	*nt*
→ Depression	.62	.81	***	.57	.78	***

Note: *nt* means not tested for significance because this loading was fixed to 1.00 to scale a factor
*** p<.001

Regarding path coefficients in the structural model, multi-group analysis showed that out of the 12 parameters, only one, a direct effect of violence on psychological outcomes, was statistically different between Caucasians and Asians. Separate group analysis supported this result indicating that for Caucasians, level of violence had no direct effect on psychological outcomes, while the level of violence had direct effect on psychological outcomes for Asians (β =.72, p =.003). Level of violence had a direct effect on perceived social support (β =-.29, p

=.008) for Caucasians, while there was no relationship between violence and perceived social support among Asians. Regarding passive coping, the direct effect of violence on coping was found in the Caucasian group (β = .39, p =.002), but not in Asian group. Perceived social support was found to be significantly related to psychological outcomes in the Caucasian group (β =-.41, p <.001), while there was no relationship in the Asian group. There was no significant relationship between violence and problem-focused coping in the Caucasian group, while there was significant relationship in the Asian group (β =.46, p =.017). There was no relationship between violence and seeking support in the Caucasian and the Asian groups. For both groups, there was no significant relationship between problem-focused coping and psychological outcomes and between seeking social support and psychological outcomes. Perceived social support had a direct effect on problem-focused coping for Caucasians (β =.26, p =.037), while a significant relationship was not found for Asians. Perceived social support had a direct effect on seeking support for Caucasians (β =.42, p <.001) and Asians (β =.40, p =.012). Regarding the relationship between perceived social support and passive coping, a significant relationship was not found for both groups. Regarding direct effect of passive coping on psychological outcomes, only the Caucasian group showed the direct effect (β =-.47, p= <.001). Table 5.17 presents path coefficients for the Caucasian and the Asian groups. Figure 5.4 and 5.5 depict factor loadings in measurement model and path coefficients in the structural model for Caucasians and Asians.

5.17 Path Coefficient in Structural Model

	Caucasian			Asian		
	B	β	P	B	β	P
Level of Domestic Violence (VIOLENCE)						
→ Psychological Outcomes	.02	.09	.369	.14	.72	.003
→ Perceived Social Support	-.05	-.29	.008	-.00	-.02	.886
→ Problem Focused Coping	.01	.07	.550	.06	.46	.017
→ Seeking Social Support	-.00	-.02	.864	.06	.33	.056
→ Passive Coping	.03	.39	.002	.04	.36	.055
Perceived Social Support (PSS)						
→ Psychological Outcomes	-.47	-.41	***	-.23	-.16	.303
→ Problem Focused Coping	.16	.26	.037	.19	.21	.179
→ Seeking Social Support	.43	.42	***	.54	.40	.012
→ Passive Coping	-.04	-.09	.421	-.21	-.29	.079
Problem Focused Coping (PF)						
→ Psychological Outcomes	-.19	-.10	.579	-.289	-.53	.507
Seeking Social Support (SS)						
→ Psychological Outcomes	.19	.17	.388	-.075	.03	.950
Passive Coping (PC)						
→ Psychological Outcomes	1.14	.47	***	.55	.29	.453

Figure 5.4 Factor loadings in measurement model and path coefficients in structural model for Caucasians

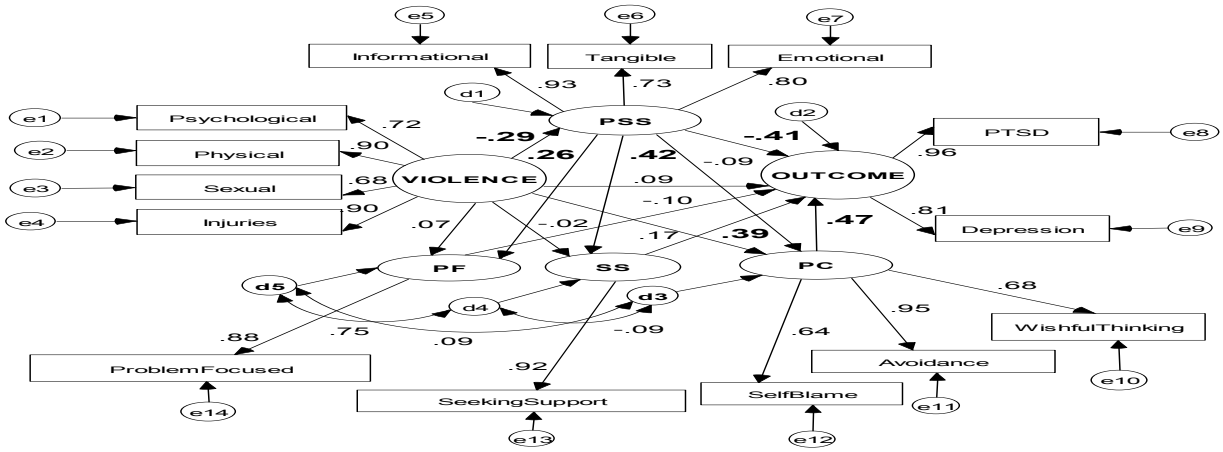
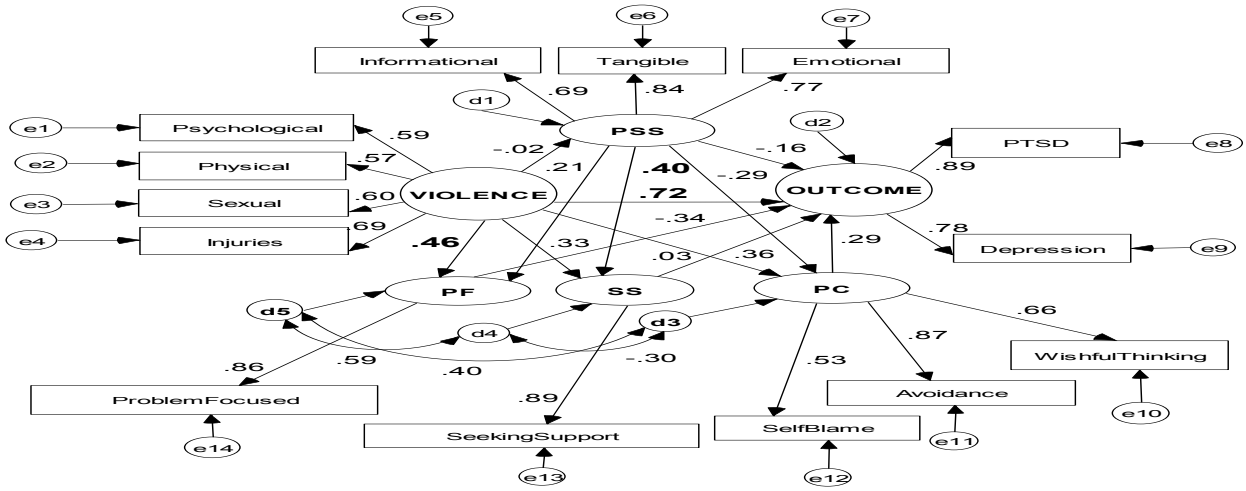


Figure 5.5 Factor loadings in measurement model and path coefficients in structural model for Asian



7.3. Additional comparison

In addition to between group differences related to the hypothesis, several other group differences were examined including variance of latent variables and covariance between latent variables. Squared multiple correlations (SMC) show the proportion of the explained variance in the latent variable. For the Caucasian group, 48% of the variance associated with psychological outcomes was accounted for by five predictors of violence, perceived social support, seeking support, problem- focused coping, and passive coping. For the Asian group, 64% of the variance associated with psychological outcomes was accounted for by five predictors of violence, perceived social support, seeking support, problem- focused coping, and passive coping. Nine percent of the variance associated with perceived social support was accounted for by level of violence for the Caucasian group, while almost zero % of the variance associated with perceived social support was accounted for by level of violence in the Asian group. Six percent of the variance associated with problem –focused coping was accounted for by violence and perceived social support in the Caucasian sample, while 25% of the variance associated with problem – focused coping was accounted for by violence and perceived social support in the Asian sample. Eighteen percent of the variance in seeking support was accounted for by violence and perceived social support in the Caucasian sample, while 27% of the variance in seeking support was accounted for by violence and perceived social support in the Asian sample. Eighteen percent in passive coping was accounted for by violence and perceived social support in the Caucasian sample, 21% in passive coping was accounted for by violence and perceived social support in the Asian sample.

Regarding correlations among latent error terms, there seem to be differences between the Asian and Caucasian samples. For both groups, there was a high level of correlation between the error terms for problem-focused coping and seeking social support. Regarding correlations between problem-focused coping and passive coping for error terms, for both groups, significant correlations were not found. However, Asians showed stronger values (r =.094 for Caucasians; r =.396 for Asians). Similarly, for both groups, significant correlations were not found between seeking support and passive coping.

CHAPTER VI
DISCUSSION

The purpose of this study was to examine the relationship between domestic violence and psychological outcomes among abused women. Moreover, this study assessed the role of social support and coping in mediating violence-psychological outcome relations. Previous empirical research has focused mainly on the relationships between domestic violence and psychological outcomes, with little emphasis on mediating the effects. Another aspect of interest in this study was to investigate whether these findings were invariant across groups differing by ethnicity, Caucasian vs. Asian women. Structural Equation Modeling (SEM) was used to investigate the relationships among violence, social support, coping, and psychological outcomes and to examine ethnic differences in these relationships. The central hypotheses regarding perceived social support and coping as a mediator of the relationship between level of violence and psychological outcomes were supported. However, the ethnic group comparison revealed that these hypotheses were supported by the Caucasian group only. In the Asian group, while there was a direct effect of violence on psychological outcomes, the mediating role of perceived social support and coping was not found. This chapter consists of three sections. The first section presents salient findings of descriptive and structural equation modeling analyses, as well as comparisons of current results with prior studies. The second section discusses limitations of this study. Finally, implications for social work practice, policy and the future research are discussed.

I. Discussion

1. The Salient Findings of Descriptive Analysis

This study consists of a sample of 100 Caucasian women and 61 Asian women who have experienced domestic violence during the past year and who were recruited from domestic violence agencies in Texas and California. Regarding the demographic characteristics of participants, Caucasian and Asian groups differed on employment, current marriage status, history of sexual abuse during childhood and adolescents, and current living situation. Based on the previous studies, several demographic variables were examined in order to determine if these variables were significant factors influencing victims' psychological outcomes. These variables included length of relationship with an abusive partner, religiosity, history of sexual abuse, living at shelter, living with children, and employment. Correlational analysis revealed that none of the variables were significantly related to the outcome variables except living at the shelter. These results were contrary to the previous studies that suggest employment (Hughes & Jones, 2000), children in the home (Hughes & Jones, 2000), duration of abusive relationship (Browne, 1993; Herman, 1992), childhood sexual abuse (e.g., Hein, et al., 2000; Kemp et al., 1995; Schiff et al., 2002), and religiosity (Levin, Markides & Ray 1996; Musick et al. 1998) were significant factors influencing victim's psychological outcomes. In this study, there was a moderate association between living at a shelter and psychological outcomes for the Caucasian group. However, there is a possibility that the demographic variables indirectly influenced the outcomes. For example, history of sexual abuse may influence psychological outcomes indirectly through social support or coping. However, detecting these relationships was not a primary interest of this study. Further studies need to explore these possible relationships.

Another interesting finding was related to the high prevalence of depression and PTSD symptoms among sample data. The prevalence of depression symptoms, as measured by the Center for Epidemiologic Studies-Depression Scale (with a cutoff ≥ 16), was 84% for Caucasian women and 97% for Asian women. In previous studies, the rate of depression in abused women across diverse samples ranged from 38% to 83% (Campbell et al., 1995; Cascardi, & O'Leary, 1992; Cascardi, O'Leary, & Schlee, 1999). The prevalence of PTSD symptoms, as measured by the PTSD- Checklist (with a cutoff ≥ 50), was 60% for Caucasian women and 67% for Asian women. In previous studies, the rate of PTSD in abused women across diverse samples ranged from 31% to 84% (Cascardi, O'Leary, & Schlee, 1999; Gleason, 1993; Kemp et al., 1991). In both groups, PTSD and depression were highly correlated, which means that these disorders could be reflecting one dimension of psychological distress. This result is consistent with Stein and Kennedy's work (2001).

2. The Salient Findings of Structural Equation Modeling

2.1. Combined group analysis

The results of this study indicated that there was no direct effect of violence on psychological outcomes. Rather, there was an indirect effect of violence on psychological outcomes through the mediating variables of perceived social support and passive coping. Although a direct effect of violence on psychological outcomes was found in a number of previous studies (Cascardi, O'Leary, Schlee, 1999; Gelles & Straus, 1989; Tuel & Russell, 1998; Vitanza, Vogel, & Marshall, 1995), social support and coping were not taken into consideration in these previous studies. In the current study, without controlling for social support and coping,

a direct effect of violence on psychological outcomes was found. However, in the full model, which considers the role of social support and coping as mediators, the direct effect of violence on psychological outcomes was not found. These findings, therefore, provide evidence to suggest that social support and coping in this model play a key role in understanding the recovery process for victims of domestic violence.

Perceived social support was an important mediator between partner violence and psychological consequences. These results suggest that high levels of violence are associated with a lowered perceived social support, which in turn is associated with higher levels of adverse psychological symptoms. In other words, perceived social support was eroded by increased violence, and abused women with lower perceived social support presented with higher distress levels. While there are inconsistent findings in the previous studies using samples of battered women in terms of whether perceived social support acts as a moderator (Coker et al., 2003) and a mediator (Thompson et al., 2000; Kemp et al., 1995), the results of the current study supports the mediator role of perceived social support between level of violence and psychological outcomes.

The findings that there is a direct negative effect between level of violence and perceived social support are consistent with previous studies indicating that battered women experience a lack of tangible and emotional support (Browne, 1997; Dobash, et al., 1985; Gelles, 1979; Mitchell & Hodson, 1983; Sullivan et al., 1992). Domestic violence is defined not only as a violent act but also as the control of a partner. An increase in levels of violence means an increase in the control of the partner. Therefore, women who experience more severe and

frequent violence may experience more isolation from family, friends, and formal networking, which leads to the lack of available social support.

The findings that there is a direct negative effect between perceived social support and psychological outcomes is consistent with the previous studies. These studies suggest that lower levels of perceived social support are related to greater symptomatology among battered women (Arias, 1999; Cocker et al., 2002; Giles-Sims, 1998; Kemp et al., 1995; Tan et al., 1995; Thompson et al., 2000).

Another interesting finding was related to the role of passive coping as a mediator. While neither problem-focused coping nor seeking support mediated the relationship between violence and psychological outcomes, passive coping was an important mediator between violence and psychological consequences. These results are consistent with previous studies (Kemp et al., 1995; Mitchell & Hodson, 1983). Kemp et al. (1995) suggest that disengagement coping was a mediator between violence and PTSD symptoms, whereas engagement coping was not. Similarly, Mitchell and Hodson (1983) found that increasing frequency and severity of violence are associated with greater use of avoidance coping, which is associated with more severe psychological distress. However, these indirect effects were not found in active cognitive and active behavior coping.

The present study indicated that there is a direct effect of violence on passive coping which is consistent with Vitanza et al.'s study (1995) that suggests cognitive difficulty resulting from repeated battering leads the victims to engage in ineffective and self-defeating problem solving. However, this result is contrary to Hamby and Gray-Little's work (1997) that suggests women who experienced greater levels of violence exhibited more active behaviors and fewer

passive responses than those who had experienced less aggression. The findings that there is a relationship between passive coping and psychological distress are consistent with Arias and Pape's study (1999) indicating that emotion-focused coping was related to PTSD.

The present study also examined the relationship between perceived social support and coping. There was a direct effect of perceived social support on problem-focused coping and a direct effect of perceived social support on seeking support. These results suggest that social support encouraged women to utilize problem-focused coping and help-seeking. Similarly, there was a direct effect of perceived social support on passive coping. This result implies that lower levels of perceived social support are associated with a greater amount of passive coping. These results are consistent with the previous studies suggesting that social support precedes and influences coping (McColl et al., 1995; Nurius, et al., 1992; Thoits, 1986; Lazarus and Folkman, 1984). These findings are also consistent with the previous studies demonstrating that social support enabled greater active coping efforts in battered women (Mitchell & Hodson, 1983; Sullivan et al., 1992).

2.2. Ethnic group comparison

Given the small sample size of the Asian group, the differences which were found in the separate group analysis may be the most interpretable. Based on the separate group analysis, a visual inspection of the standardized structural parameters was conducted to examine the differences in the patterns of the interrelationships among variables between groups. The results of hypotheses concerning the direct effects of violence on psychological outcomes differ across groups. For Asians, there was a strong relationship between violence and psychological

outcomes, whereas such direct effects were not found for Caucasians. For Asians, the effect of violence on psychological outcomes was entirely direct, which implies that violence was found to have no significant indirect effects on outcomes via mediating variables of perceived social support and coping. On the other hand, for Caucasians, the effects of violence on outcomes were only indirect through mediating variables of perceived social support and coping. For Asian women, the higher the level of violence experienced, the more severe the psychological distress symptoms. Strong direct effects of violence on outcomes without mediators filtering the direct impact may imply that Asians are more vulnerable to adverse psychological outcomes following domestic violence.

While perceived social support was an important mediator between domestic violence and psychological outcomes in the Caucasian group, perceived social support did not mediate the relationship between the level of violence and psychological outcomes in the Asian group. In other words, while for Caucasian women, social support contributed to reducing the impact of violence on psychological distress, for Asians, such a role of perceived social support was not discovered. More surprisingly, in the Asian group, there was no relationship between perceived social support and psychological outcomes. This finding was in contrast to previous studies using non-victim Asian samples (Snowden & Cheung; Lee, Crittenden, & Yu, 1996; Mui, 1998; Kim, 1999) that suggested higher levels of social support were associated with lower levels of distress.

There are several possible explanations for these results. First, the small sample size among the Asian group might hamper the power to detect a significant relationship. A second possible explanation is that social support systems which appear to work well in improving psychological health in the general population may not work for Asian women who are in

abusive relationships. This alternative explanation may be related to Asians' attitudes toward domestic violence and Asian cultures, which put strong emphasis on family harmony and family face (Ho, 1990; Lee, 2002, Yamashiron & Matsuoka, 1997). Although members of Asian communities in the United Sates have become increasingly aware of the problem of domestic violence, domestic violence is still considered a private issue and victim-blaming attitudes are still prevalent (Yoshioka & Dang, 2000). According to Yoshioka and Dang (2000), Asian women try to solve problems by themselves and not disclose the family secret to prevent shaming to the family. In addition, since there is a great amount of stigma regarding divorce among Asian communities, Asian women may want to attempt to end the abuse and keep the family together simultaneously (Lee, 2002). Also, Asians may feel that the support they do receive is less beneficial because their efforts to utilize formal services may be frustrated by cultural or language barriers, as well as a lack of knowledge about appropriate resources such as legal services (Yoshihama, 1999). Therefore, even though social support is available, these barriers make the women feel trapped in abusive marriages, which may make the existing social support systems ineffective in reducing the adverse psychological symptoms. The current study considered perceived social support only. Received social support may have different roles in the violence-psychological outcome relations.

Neither problem-focused coping nor seeking support mediated the relationship between violence and psychological outcomes in both groups. On the other hand, passive coping acted as a mediator between levels of violence and the psychological outcomes in the Caucasian group. In the Asian group, passive coping did not mediate the relationship between violence and outcomes. This finding was in contrast to Lee and Lui's study (2001) using non-victim Asian samples

indicating that passive coping mediated the effect of family conflict on psychological distress. Surprisingly, in the Asian group, there was no relationship between passive coping and psychological outcomes. This result was in contrast to previous studies using non-victim Asian samples (Chang, 1996; Um & Dancy, 1999) that suggest passive coping was a significant predictor of psychological distress. However, the results of the current study are consistent with Yoshihama's study (2002) that suggests there was no relationship between the type of coping and psychological distress of battered women. Instead, she found that there was a relationship between the perceived effectiveness of active and passive strategies and psychological distress, indicating that the higher the perceived effectiveness of passive strategies, the lower their psychological distress. However, replication of the current study with larger samples is needed to confirm these relationships among Asian populations.

Regarding the relationship between social support and coping, for both groups, perceived social support was a predictor of seeking support. In other words, social support encouraged women to seek help for their problems. However, as this study indicated earlier, such coping efforts did not contribute to a reduction in adverse psychological outcome following domestic violence. Future studies examining the linkage between active coping and psychological outcomes are needed.

II. Limitations

This study provided valuable information regarding the role of social support and coping in mediating the violence-psychological outcome relations. In addition, this study presented useful information concerning the differential impact of domestic violence, social support, and

coping on psychological outcomes between Caucasian and Asian women. However, the findings from this investigation need to be viewed in light of several limitations.

First, due to the cross-sectional design of this study, causality cannot be determined. Since time-order was not taken into account, this study cannot determine the correct temporal sequence in terms of domestic violence, social support, coping, and health outcomes. It is possible that some relationships operate in the opposite direction. Briere (1992) cautions that the correlational and retrospective nature of many trauma studies can blur cause and effect. For example, it could be argued that although coping strategies mediate traumatic responses, the reverse could also be true. That is, current levels of distress may influence selection of coping strategies. A longitudinal study can clarify the casual processes leading to psychological outcomes.

Another limitation of this study was the sampling. The fact that subjects consisted of those who were accessing formal assistance for domestic violence restricts the generalizability of the findings. The women who have not sought outside assistance were excluded from this study. Especially for Asians, only a small fraction of battered women use shelters or domestic violence agencies (Yoshioka & Dang, 2000). The levels of social support and coping strategies among Asian women who have not sought outside assistance may differ from the current study sample. In addition, because of the limited number and availability of Asian women in domestic violence shelters, only a small number of the Asian participants were obtained from a shelter living situation, while a larger number of Caucasian participants were drawn from a shelter living situation. A future study needs to investigate differences between a shelter and non-shelter sample. In addition, this study did not identify the diversity among Asians. Although these Asian

groups of Koreans, Chinese, and Vietnamese are strongly influenced by Confucianism (Hong, Yamamoto, Chang & Lee, 1993; Park & Cho, 1995; Tran & Jardins, 2000; Yamashiro & Matsuoka, 1997), which provides strict moral standards and discipline, there is still possibility of differences among these groups. Therefore, caution should be used when generalizing the results of the present study to other abused women, including Caucasian and Asian populations as a whole.

Another limitation was the use of measures that had not previously been validated for Asian populations. Although this study revealed that these translated measurements are reliable and valid for Asians, coefficient alpha and factor loadings of Asians were lower than those of Caucasians, which may imply that the measurements for the Asian group were less reliable and less valid than those for the Caucasian group. Furthermore, these measurements were translated into three different languages. However, because of the small subgroup sample size, this study did not test reliability and validity for each group.

In addition, the data for this study was collected via self-report measures. Self-report is influenced by social desirability, which is the tendency of respondents to provide information in the socially desirable direction.

Another limitation was sample size. The total sample used for testing a combined model did exceed the recommended minimum sample size. However, in the multi-group analysis, while the Caucasian sample only falls slightly below the recommended minimum sample size, the Asian sample falls below the recommended minimum sample size. Because of the realities of collecting data in a clinical setting, very unequal group size existed for Caucasian and Asian abused women. Recruiting the Asian participants posed several challenges. Although there are

huge numbers of Asians in TX (over 560,000), there were only a few agencies which mainly provide services for Asian victims of domestic violence. None of those agencies provide shelter services for abused women. Another challenge was related to a resistance from Asian domestic violence agencies to allow the researcher to conduct the victim survey. The staff members indicated that since there is a strong stigma toward domestic violence in Asian communities, the victims are very sensitive to participating in this type of survey. Because the Asian group was small, the statistical tests did not possess enough power to effectively test for the invariance of paths across the models for Caucasians and Asians. This limitation precluded generating stronger conclusions about the ways in which Caucasian women and Asian women differed on these relationships. The results of the present study need to be replicated with a larger sample to confirm the relationship among constructs found with the sample of the present study.

III. Implications

1. Implications for Social Work Practice

The findings of the current study provide implications for social workers and other practitioners working for mental health services and domestic violence agencies. High levels of adverse psychological outcomes among abused women in the study suggest the need for a linkage between mental health services and domestic violence services. Women may present to health-care settings before they present to social service agencies. Women may present to social services agencies to seek help without addressing psychological problems although they suffer from trauma, which may result from victims' lack of awareness of the trauma of domestic

violence. Mental health practitioners need to routinely assess for domestic violence and understand the nexus between domestic violence and adverse psychological outcomes, such as PTSD and depression. Similarly, domestic violence service practitioners need to be sensitized to victims' psychological health status and to assist the victims in psychological recovery. In addition to understanding the interplay between domestic violence and psychological damage, service providers working with victims of domestic violence need to identify significant risk and protective factors that differentiate levels of adverse psychological outcomes following domestic violence. This study found that passive coping was a risk factor that increases vulnerability to traumatic responses following domestic violence. On the other hand, social support was a protective factor that decreases such vulnerability. Although problem-focused coping and help seeking are considered effective in a number of previous studies, the findings of the current study did not support the previous studies. It is important to find a linkage between these active coping efforts and psychological health. Service providers need to identify whether such coping efforts provide benefits to the victims in reality and what the barriers may be that the victims face in utilizing these coping strategies.

In addition, service providers need to educate victims about the psychological consequences following domestic violence. Even though victims suffer from traumatic symptoms following domestic violence, they may not address these problems with service providers because they think that these traumatic symptoms are not related to their experiences of domestic violence. Also, they may not address these problems because of shame and stigma. The stigma of mental illness and domestic violence may contribute to the victims not disclosing the problems and make victims' efforts to overcoming their situations harder.

The findings of this study provide valuable information especially for service providers working with Asian populations. This current study shows the extent to which Asian victims of domestic violence are vulnerable to trauma following domestic violence. The previous studies discuss that in Asian communities there are strong stigma and shame related to domestic violence (McDonnell & Abdulla, 2002; Yoshioka, et al., 2000) and mental illness (Lin, Inui, Kleinman, & Womak, 1982; Shin, 2002). In other words, in addition to violence experiences, adverse psychological symptoms themselves are shameful experiences for Asians. Therefore, it is important to educate the public about the psychological damage caused by domestic violence, not just to the woman but the family and community as a whole.

As this study indicated, social support will provide a very important role in reducing adverse psychological outcomes following domestic violence. However, for Asians, these supports did not appear to have a critical role in successful recovery from an abuse event. Service providers should be aware that social supports, which are helpful for Caucasians, may not be helpful for Asians. Cultural context should be considered. Since separation and divorce are highly stigmatized, and for immigrant women in particular, living independently from their husbands may isolate them from their extended family and community, most Asian women want to find ways to keep their family together and end the abuse. To protect family face and the family unit, Asian women may experience cultural pressures to internalize the problem. These complexities indicate how much community education is needed. Asian women rely heavily on informal rather than formal networks. If community members are well aware of the fact that domestic violence is a violent act and it causes significant damage to victims' psychological health as well as physical health, there may be more community involvement in resolving these

issues. Community members may play a positive role in healing the trauma of domestic violence. Without awareness of these issues among family and community members, however, the victims may be revictimized when they seek help from informal social network.

Barriers to access available resources should also be considered. In other words, information on resources and supportive services need to be made easily accessible to battered women, especially Asian battered women. Immigrant women may be reluctant to use legal enforcement because of their own precarious immigration status or because of earned mistrust (Yoshioka et al., 2000). Service providers should educate abused women about victim's rights and courts in order to alleviate fear.

2. Implications for Policy

The results of this study support previous studies that have consistently shown the harmful effects of domestic violence on victims. The results of this study suggest the possibility that social workers could play an active role in advocating on behalf of abused women. Implied in many of the issues addressed by this study is the need to vigorously advocate for abused women's rights, increasing the social support for them. It is important to address the high prevalence of negative psychological outcomes in abused women. The treatment of psychological distress, such as PTSD and depression, should be an integral part of the recovery from battering. In addition, barriers that make it difficult for abused women to seek help should be addressed to policy makers, highlighting the cultural and institutional barriers Asian battered women confront. These barriers include feelings of shame, lack of fluency in English, complex immigration policies, and cultural insensitivity ingrained in many areas that traditionally offer

protection to battered women (McDonnell & Abdulla, 2002; Yoshioka, et al., 2000). Funding is needed for community outreach and education. Public policy campaigns focused on educating women of diverse ethnic backgrounds about domestic violence could lead to less stigma and more social support for these women. In addition, since there is a strong resistance to speaking out about the issues of domestic violence among Asian communities, collaborations with community organizations are very important to outreach services. In particular, religious organizations could play a very important role in bridging the gap between victims and victim service agencies.

There also needs to be a linkage between battered Asian women and the legal system. The immigration provisions of Violence Against Women Act (VAWA) reauthorized in 2000 allow immigrant battered women to report abuse without fear of deportation and to obtain permanent immigration status without leaving the United States. Such acts may not be feasible for Asians unless detailed information, such as purpose, eligibility, and filing processes, is clearly explained in the victims' language. When women start filing, they may face a great deal of resistance from family members or community members. There is strong resistance to taking legal actions among Asians in communities because Asians think such actions will cause family break-up. In addition, women may feel embarrassed and frustrated when finding an interpreter, especially a court interpreter. Finding a professional interpreter is not easy for abused women in terms of costs and accessibility. Such concerns faced by Asian women should be addressed and adequate assistance should be provided.

Another implication regarding policy development is related to funding for research. Although there has been a tremendous amount of research on the topic of domestic violence,

very little of it has included psychological distress among victims of domestic violence. Furthermore, very limited attention has been given to Asian victims' psychological health. However, information such as this is vital to service planning, community education and outreach planning, and community and victim advocacy. Much more information about Asian victims needs to be gathered. Research will assist in promoting legislative and policy changes necessary to improve the treatment of victims of domestic violence and meet the needs of underserved populations.

3. Implications for Future Research

While there is a growing body of knowledge becoming available on victims of domestic violence, there has been little empirical research examining the role of social support and coping leading to improved psychological health. The results of this study contribute to a better understanding about the complex nature of violence, social support, coping and psychological outcomes. The generalizability of the results of the current study are of course limited by its sample size, but they do provide a starting point for understanding the ethnic differences in associations among violence, social support, coping and psychological outcomes.

Further studies should examine these relationships with longitudinal data to determine whether the patterns are consistent over time and to gain greater information on the nature of relationships among social support and coping, and psychological distress. In the present study, neither problem-focused coping nor seeking support mediated the recovery process with positive outcomes. It is recommended that future research include potential variables that may mediate between these types of coping and psychological outcomes, such as perceived effectiveness of

the coping strategies. The effect of social support given by informal networks and its link to instrumental support provided by the professional section is a critical area for continued research. Especially, for Asians, there may be a lack of such linkages due to cultural and institutional barriers.

This study did not take into account the effects of demographic variables in the associations among violence, social support, coping, and violence. This study only examined the relations between demographic variables and psychological outcomes variables prior to SEM analysis. However, future studies need to examine the dynamics among these demographic variables and predictor variables of violence, social support, and coping, for instance, asking whether there is an indirect effect of history of sexual abuse or employment on psychological outcomes via either violence, social support, or coping. In addition, future studies might look at both the length of shelter residence and length of abusive relationships as factors related to psychological outcomes.

Based on the findings of this study, the impact of violence on psychological outcomes differed across ethnic groups, and social support and coping were considered variables explaining such differences. However, this study did present clearly why the roles of social support and coping differed from one another. Future studies need to explore cultural factors that would lead to a better understanding of the ethnic differences in the effects of social support and coping on the relationship between violence and psychological outcomes, such as familism, attitudes toward domestic violence, responses from family, friends, and community members when the victims ask for help.

Appendix A

Consent Form

Consent Form

Psychological Health In Asian And Caucasian Women Who Have Experienced Domestic Violence: The Role Of Ethnic Background, Social Support, and Coping.

You are invited to participate in a study examining factors affecting psychological health following domestic violence. My name is Joohee Lee and I am a doctoral student at The University of Texas at Austin, School of Social Work. This study is a part of my doctoral dissertation. The purpose of this study is to examine how coping strategies and social support influence individual's psychological health following domestic violence. This study also explores how an individual's ethnic background influences these relationships.

If you decide to participate, you will be asked questions that will take approximately 30 to 45 minutes to complete. You will be asked questions regarding your experience of domestic violence, psychological distress following domestic violence, social support systems, coping style, childhood sexual abuse, drinking alcohol, and several background information, such as age and marital status. Your participation is voluntary. Your decision to participate will not affect your future relations with the organizations which you are involved. Also, you may chose not to respond to any questions that you feel uncomfortable answering. Any information that is obtained in connection with this study will remain confidential and will not be disclosed.

There are no known or expected risks from participating in this study, except for the discomfort association with responding personally distressing experiences. Because of this, you have the right to refuse to answer any questions.

If you disclose information about abuse to a child, the researcher must legally report this information to Child and Family Protective Services, if this information is not already known to them. In addition, if you disclose information about injury to self or others, the researcher must report this information to the proper authorities. The researcher will give you a list of resources that you can be referred to.

The possible benefit of your participation is that the results of the survey may help service providers and agencies improve their programs. You will receive $10 gift card to compensate for your time.

Thanks for your assistance. If you wish to stop your participation in this research study for any reason, you should contact: Joohee Lee, doctoral student of social work at The University of Texas at Austin (Tel:512 - 796-9184; Email:jhl@mail.utexas.edu), or chair of my dissertation committee, Dr. Elizabeth C. Pomeroy (Tel:512 – 232 – 405;Email:bpomeroy@mail.utexas.edu).

You are free to withdraw your consent and stop participation in this research study at any time without penalty or loss of benefits for which you may be entitled. In addition, if you have questions about your rights as a research participant, please contact Clarke A. Burnham, Ph.D.,

Chair, The University of Texas at Austin Institutional Review Board for the Protection of Human Subjects, 512/232-4383.

_____	_____
Signature of Participant	Date
_____	_____
Signature of Researcher	

Appendix B

English Version of Questionnaires

* Using the scale (0 to 3) below, indicate the number which best describes how often you felt or behaved this way **during the past week**.

0 = Rarely or none of the time (less than 1 day)

1 = Some or a little of the time (1 - 2 days)

2 = Occasionally or a moderate amount of time (3 - 4 days)

3 = Most or all of the time (5 – 7 days)

1.	I was bothered by things that usually don't bother me.	0	1	2	3
2.	I did not feel like eating: my appetite was poor.	0	1	2	3
3.	I felt that I could not shake off the blues even with help from my family or friends.	0	1	2	3
4.	I felt that I was just as good as other people.	0	1	2	3
5.	I had trouble keeping my mind on what I was doing.	0	1	2	3
6.	I felt depressed.	0	1	2	3
7.	I felt that everything I did was an effort.	0	1	2	3
8.	I felt hopeful about the future.	0	1	2	3
9.	I thought my life had been a failure.	0	1	2	3
10.	I felt fearful.	0	1	2	3
11.	My sleep was restless.	0	1	2	3
12.	I was happy	0	1	2	3
13.	I talked less than usual.	0	1	2	3
14.	I felt lonely.	0	1	2	3
15.	People were unfriendly.	0	1	2	3
16.	I enjoyed life.	0	1	2	3
17.	I had crying spells.	0	1	2	3
18.	I felt sad	0	1	2	3
19.	I felt that people disliked me.	0	1	2	3
20.	I could not get "going."	0	1	2	3

* Below (question # 1- 17) is a list of problems and complaints that people sometimes have in response to stressful experiences. As a result of any of your partner's abuse (physical, emotional, or sexual abuse) of you, please indicate how much you have been bothered by that problem **in the past one month.**

1 = Not at all
2 = A little bit
3 = Moderately
4 = Quite a bit
5 = Extremely

1.	Repeated, disturbing memories, thoughts or images of the abuse.	1	2	3	4	5
2.	Repeated, disturbing dreams of the abuse.	1	2	3	4	5
3.	Suddenly acting or feeling as if the abuse was happening when it wasn't (as if you were reliving it).	1	2	3	4	5
4.	Feeling very upset when something reminded you of the abuse.	1	2	3	4	5
5.	Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of the abuse.	1	2	3	4	5
6.	Avoiding thinking about or talking about the abuse or avoiding having feelings related to the abuse.	1	2	3	4	5
7.	Avoiding activities or situations because they remind you of the abuse.	1	2	3	4	5
8.	Trouble remembering important part of the abusive episodes.	1	2	3	4	5
9.	Loss of interest in activities you used to enjoy.	1	2	3	4	5
10.	Feeling distant or cut off from other people	1	2	3	4	5

In the past one month

1 = Not at all

2 = A little bit

3 = Moderately

4 = Quite a bit

5 = Extremely

11. Feeling emotionally numb or unable to have loving feelings for those close to you.	1	2	3	4	5
12. Feeling as if your future somehow will be cut short.	1	2	3	4	5
13. Trouble falling or staying asleep.	1	2	3	4	5
14. Feeling irritable or having angry outburst.	1	2	3	4	5
15. Having difficult concentrating.	1	2	3	4	5
16. Being super alert or watchful.	1	2	3	4	5
17. Feeling jumpy or easily startled.	1	2	3	4	5

* Please read the following statements (questions # 1 -33) very carefully and circle the appropriate number, from 0 to 7, which best corresponds with how many times did your partner did the following behaviors during the past one year.

0 = Never happened
1 = 1 time
2 = 2 times
3 = 3-5 times
4 = 6-10 times
5 = 11-20 times
6 = More than 20 times

7 = Not in the past year, but it happened before

1. My partner insulted or swore at me.	0	1	2	3	4	5	6	7
2. My partner shouted or yelled at me.	0	1	2	3	4	5	6	7
3. My partner stomped out of the room or house or yard during a disagreement.	0	1	2	3	4	5	6	7

During the past one year

0 = Never happened
1 = 1 time
2 = 2 times
3 = 3-5 times
4 = 6-10 times
5 = 11-20 times
6 = More than 20 times

7 = Not in the past year, but it happened before

4. My partner said something to spite me.	0	1	2	3	4	5	6	7
5. My partner called me fat or ugly.	0	1	2	3	4	5	6	7
6. My partner destroyed something belonging to me.	0	1	2	3	4	5	6	7
7. My partner accused me of being a lousy lover.	0	1	2	3	4	5	6	7
8. My partner threatened to hit or throw something at me.	0	1	2	3	4	5	6	7
9. My partner threw something at me that could hurt.	0	1	2	3	4	5	6	7
10. My partner twisted my arm or hair.	0	1	2	3	4	5	6	7
11. My partner pushed or shoved me.	0	1	2	3	4	5	6	7
12. My partner grabbed me.	0	1	2	3	4	5	6	7
13. My partner slapped me.	0	1	2	3	4	5	6	7
14. My partner used a knife or gun on me.	0	1	2	3	4	5	6	7
15. My partner punched or hit me with something that could hurt.	0	1	2	3	4	5	6	7
16. My partner chocked me.	0	1	2	3	4	5	6	7
17. My partner slammed me against a wall.	0	1	2	3	4	5	6	7
18. My partner beat up me.	0	1	2	3	4	5	6	7
19. My partner burned or scaled me on purpose.	0	1	2	3	4	5	6	7
20. My partner kicked me.	0	1	2	3	4	5	6	7

During the past one year

0 = Never happened
1 = 1 time
2 = 2 times
3 = 3-5 times
4 = 6-10 times
5 = 11-20 times
6 = More than 20 times

7 = Not in the past year, but it happened before

21. My partner made me have sex without a condom.	0	1	2	3	4	5	6	7
22. My partner insisted on sex when I did not want (but did not use physical force).	0	1	2	3	4	5	6	7
23. My partner insisted me have oral or anal sex (but did not use physical force).	0	1	2	3	4	5	6	7
24. My partner used force (like hitting, holing down, or using a weapon) to make me have oral or anal sex.	0	1	2	3	4	5	6	7
25. My partner used force (like hitting, holing down, or using a weapon) to make me have sex.	0	1	2	3	4	5	6	7
26. My partner used threats to make me have oral or anal sex.	0	1	2	3	4	5	6	7
27. My partner used threats to make me have sex.	0	1	2	3	4	5	6	7
28. I had a sprain, bruise, or small cut because of a fight with my partner.	0	1	2	3	4	5	6	7
29. I felt physical pain that still hurt the next day because of a fight with my partner.	0	1	2	3	4	5	6	7
30. I passed out from being hit on the head by my partner in a fight	0	1	2	3	4	5	6	7
31. I went to a doctor because of a fight with my partner.	0	1	2	3	4	5	6	7
32. I needed to see a doctor because of a fight with my partner, but I did not.	0	1	2	3	4	5	6	7
33. I had a broken bone from a fight with my partner.	0	1	2	3	4	5	6	7

* Please answer the following questions (Question # 1 – 15) regarding how much help and support you receive from others.

1 = Strongly Agree

2 = Somewhat Agree

3 = Somewhat Disagree

4 = Strongly Disagree

1. There are several people that I trust to help solve my problems.	1	2	3	4
2. There is no one that I feel comfortable talking to about intimate (my most private) personal problems.	1	2	3	4
3. There really is no one who can give me an objective view of how I am handling my problems.	1	2	3	4
4. If I were sick and needed someone to take me to the doctor, I would have trouble finding someone.	1	2	3	4
5. If I needed a place to stay for a week because of an emergency, I could easily find someone who would put me up.	1	2	3	4
6. I feel there is no one I can share my most private worries and fears with.	1	2	3	4
7. If I were sick, I could easily find someone to help me with my daily chores.	1	2	3	4
8. There is someone I can turn to for advice about handling problems with my family.	1	2	3	4
9. When I need suggestions (ideas) on how to deal with a personal problem, I know someone I can turn to.	1	2	3	4
10. If I needed an emergency loan of $100, there is someone I could get it from.	1	2	3	4
11. If I had to go out of town for a few weeks, it would be difficult to find someone who would look after my house or apartment.	1	2	3	4
12. It would be difficult to find someone who would lend me his/her car for a few hours.	1	2	3	4

1 = Strongly Agree

2 = Somewhat Agee

3 = Somewhat Disagree

4 = Strongly Disagree

13. I feel a strong emotional bond (connection) with at least one other person.	1	2	3	4
14. I have a feeling of intimacy (closeness) with another person.	1	2	3	4
15. I have close relationships that provide me with a sense of emotional security (safety) and well-being.	1	2	3	4

* The items below (question # 1-47) represent ways that you may have dealt with the major problem. **When partner abuse (physical, sexual, or emotional abuse) occurs, how often did you use the following thoughts/ behaviors in order to deal with the problem?**

0 = Never used

1 = Rarely used

2 = Sometimes used

3 = Regularly used

1.	I blamed myself for what happened.	0	1	2	3
2.	I concentrated on something good that could come out of the whole thing.	0	1	2	3
3.	I kept my feelings to myself.	0	1	2	3
4.	I asked someone I respected for advice and followed it.	0	1	2	3
5.	I talked to someone about how I was feeling.	0	1	2	3
6.	I stood my ground and fought for what I wanted.	0	1	2	3
7.	I refused to believe it had happened.	0	1	2	3
8.	I hoped a miracle would happen.	0	1	2	3

0 = Never used

1 = Rarely used

2 = Sometimes used

3 = Regularly used

9. I criticized or lectured myself.	0	1	2	3
10. I came up with a couple of different solutions to the problem.	0	1	2	3
11. I wished I were a stronger person.	0	1	2	3
12. I changed something about myself so I could deal with the situation better.	0	1	2	3
13. I accepted sympathy and understanding from someone.	0	1	2	3
14. I slept more than usual.	0	1	2	3
15. I realized I brought the problems on myself.	0	1	2	3
16. I felt bad that I couldn't avoid the problem.	0	1	2	3
17. I knew what had to be done, so I doubled my efforts and tried harder to make things work.	0	1	2	3
18. I suggested that the partner get help.	0	1	2	3
19. I sought information and resources (e.g., police, legal service, shelter, financial service) through phonebook, internet, etc.	0	1	2	3
20. I daydreamed or imagined a better time or place than the one I was in.	0	1	2	3
21. I tried to forget the whole thing.	0	1	2	3
22. I got professional help and did what they recommended.	0	1	2	3
23. I changed or grew as a person in a good way.	0	1	2	3
24. I accepted my strong feelings, but didn't let them interfere with other things too much.	0	1	2	3
25. I went on as if nothing had happened.	0	1	2	3
26. I accepted the next best thing to what I wanted.	0	1	2	3
27. I talked to someone who could do something concrete about the problem.	0	1	2	3
28. I tried to make myself feel better by eating, drinking, smoking, taking medications, etc.	0	1	2	3

0 = Never used

1 = Rarely used

2 = Sometimes used

3 = Regularly used

29. I tried not burn my bridges behind me, but left things open somewhat.	0	1	2	3
30. I tried not to act too hastily or follow my own hunch.	0	1	2	3
31. I changed something so things would turn out right.	0	1	2	3
32. I avoided being with people in general.	0	1	2	3
33. I just took things one step at a time.	0	1	2	3
34. I kept others from knowing how bad things were.	0	1	2	3
35. I came out of the experience better than when I went in.	0	1	2	3
36. I prayed about it.	0	1	2	3
37. I spoke to my clergyman about the situation	0	1	2	3
38. I relied on my faith to get me through.	0	1	2	3
39. I wished that I could change what had happened.	0	1	2	3
40. I made a plan of action and followed it.	0	1	2	3
41. I talked to someone to find out about the situation.	0	1	2	3
42. I bargained or compromised to get something positive from the situation.	0	1	2	3
43. I avoided my problem.	0	1	2	3
44. I wished that I could change the way that I felt.	0	1	2	3
45. I had fantasies or wishes about how things might turn out.	0	1	2	3
46. I wished the situation would go away or somehow be finished.	0	1	2	3
47. I thought about fantastic or unreal things like the perfect revenge or finding a million dollars that made me feel better.	0	1	2	3

* Please answer the following questions (# 1-5) about religious faith using the scale blow. Indicate the level of agreement (or disagreement) for each statement.

1 = Strongly Agree

2 = Agree

3 = Disagree

4 = Strongly Disagree

1.	I pray daily.	1	2	3	4
2.	I look to my faith as providing meaning and purpose in my life.	1	2	3	4
3.	I consider myself active in my faith or church.	1	2	3	4
4.	I enjoy being around others who share my faith.	1	2	3	4
5.	My faith impacts many of my decisions.	1	2	3	4

* The following questions (# 1-4) are about abuse experiences as a child and adolescents. Circle the appropriate number, from 1 to 5, which best corresponds with how many times did you experience such incidents?

1 = Never

2 = Once

3 = 2-5 times

4 = 6-10 times

5 = More than 10 times

1.	Had someone threatened you sexually during your childhood or adolescence?	1	2	3	4	5
2.	Had someone touched you sexually against your wishes during your childhood or adolescence?	1	2	3	4	5
3.	Had someone attempted to force sexual intercourse during your childhood or adolescence? (Attempted rape)	1	2	3	4	5
4.	Had someone forced sexual intercourse during your childhood or adolescence? (Rape)	1	2	3	4	5

Background Information

The following questions (# 1 – 22) are about your general background.

1. Which year were you born? 19___ year

2. What is your ethnic background?

_____ Caucasian American _____ Korean American

_____ Chinese American _____ Vietnamese American

_____ Others (Please specify_____)

3. What is your marital status with your abusive partner?

_____ Married – living together

_____ Married – separated

_____ Divorced

_____ Never married – living together

_____ Never married – separated

_____ Others (Specify_____)

4. Do you feel that you ended the relationship with your abusive partner?

_____ Yes _____ No

5. When is the last time that the abuse (physical, emotional, or sexual abuse) occurred?

_____ One week ago
_____ Two weeks ago
_____ Three weeks ago
_____ Four weeks ago
_____ 5-8 weeks ago (2 months ago)
_____ 3 months ago
_____ 4 months ago
_____ 5 months ago
_____ 6 months ago
_____ Over 6 months ago

6. How long were you or have you been in this violent relationship?

_____ years _____ months _____ days

7. Are you currently living at a shelter?

_____ Yes _____ No (go to # 8)

7-1. If you are living at a shelter, now, how long have you been at the shelter?

_____ days

8. Do you feel that you have control over your partner's abusive behavior?

_____ Yes _____ No

9. How many children (under 18 years old) are living with you? _____

10. What is your current employment status? **(Check all that apply)**

_____	Employed full time	_____	Homemaker
_____	Employed part time	_____	Retired
_____	Full time student	_____	Others (Specify _____)
_____	Part time student		
_____	Not employed		

11. What is the highest grade of school or year of college you have completed?

Grade of School __ 00 __ 01 __ 02 __ 03 __ 04 __ 05 __ 06
__ 07 __ 08 __ 09 __ 10 __ 11 __ 12

Year of college ___ 01 ___ 02 ___ 03 ___ 04

____ Bachelors degree

____ Masters degree

____ Professional degree (JD, MD, PH.D)

____ Other

12. Did you get a high school diploma or a GED?

_____ Yes, high school diploma

_____ Yes, GED

_____ No

13. What is your total annual family income?

_____ Under $ 10,000
_____ $ 10,000 - 19,999
_____ $ 20,000 - 29,999
_____ $ 30,000 - 39,999
_____ $ 40,000 - 49,999
_____ $ 50,000 - 59,999
_____ $ 60,000 or over

14. What is your religion?

_____ Protestant Christian
_____ Catholic
_____ Buddhist
_____ Hindus
_____ Islam
_____ Confucian
_____ Non-religion
_____ Others (Specify _____)

15. How important are religious or spiritual beliefs in your day-to-day life?

_____ Extremely important
_____ Very important
_____ Moderately important
_____ A little bit important
_____ Not at all important

16. Were you born in the U.S.? _____ Yes
_____ No (go to # 16-1.)

16-1. If no, how old were you when you first came to United States?

_____ years old

16-2. How many years have you been in the United States?

_____ years _____ months

17. What language do you speak?

_____ Korean only (Vietnamese, Chinese only)
_____ Mostly Korean (Vietnamese, Chinese), some English
_____ Korean (Vietnamese, Chinese) and English about equally
_____ Mostly English, some Korean (Vietnamese, Chinese)
_____ English only

18. How would you rate your English proficiency?

_____ Poor
_____ Moderately poor
_____ Fair
_____ Good
_____ Excellent

19. Who are your close friends?

_____ Koreans only (Vietnamese, Chinese only)
_____ Mostly Koreans (Vietnamese, Chinese), some Americans
_____ Koreans (Vietnamese, Chinese) and Americans about equally
_____ Mostly Americans, some Koreans (Vietnamese, Chinese)
_____ Americans only

20. What is your food preference?

_____ Almost exclusively Korean food (Vietnamese, Chinese food)
_____ Mostly Korean (Vietnamese, Chinese) food, some American food
_____ Korean (Vietnamese, Chinese) food and American food about equally
_____ Mostly American food, some Korean (Vietnamese, Chinese) food
_____ American food only

21. What is your TV/Video preference?

_____ Almost exclusively Korean program (Vietnamese, Chinese)
_____ Mostly Korean programs (Vietnamese, Chinese), some American programs
_____ Korean programs and American programs about equally
_____ Mostly American programs, some Korean programs
_____ American programs only

22. What would you rate yourself?

_____ Very Korean (Chinese or Vietnamese)
_____ Mostly Korean
_____ Bicultural (equally Korean and American)
_____ Mostly American
_____ Very American

Thank you so much!

Appendix C
Korean Version of Questionnaires

* 다음 문장 (1번 – 20번) 은 여러분이 겪은 감정이나 느낌에 대해 알아보려고 하는 것입니다. **지난 1주일 동안** 귀하는 다음과 같은 느낌이나 감정을 얼마나 자주 경험하였는지 가장 적합한 번호에 O표 해주십시오.

지난 1주일 동안

0 = 전혀 없었거나 거의 없었다 (일주일에 1 일 미만)

1 = 간혹 있었다 (일주일에 1 - 2 일)

2 = 자주 있었다 (일주일에 3 - 4 일)

3 = 대부분 또는 거의 항상 있었다 (일주일에 5 - 7 일)

1. 평소에는 대수롭지 않았던 일들로 괴로움을 당했다.	0	1	2	3
2. 식욕이 떨어지고 먹고 싶은 생각이 들지 않았다.	0	1	2	3
3. 가족이나 주위사람들의 도움에도 불구하고 우울한 기분을 떨쳐버릴 수가 없었다.	0	1	2	3
4. 나도 남들만큼 괜찮은 사람이라고 느꼈다.	0	1	2	3
5. 내가 하는 일에 정신을 집중하기가 어려웠다.	0	1	2	3
6. 우울하게 느껴졌다.	0	1	2	3
7. 모든 일들이 다 힘겹게 느껴졌다.	0	1	2	3
8. 미래가 희망적이라고 느껴졌다.	0	1	2	3
9. 내 인생은 실패라는 생각이 들었다.	0	1	2	3
10. 두려운 마음이 들었다.	0	1	2	3
11. 잠을 설쳤다.	0	1	2	3
12. 행복했다.	0	1	2	3
13. 평소보다 말수가 줄었다.	0	1	2	3
14. 외롭게 느껴졌다.	0	1	2	3
15. 주위 사람들이 불친절 하다고 느껴졌다.	0	1	2	3
16. 삶이 즐겁다고 느꼈다.	0	1	2	3
17. 특별한 이유없이 자꾸 눈물이 나왔다.	0	1	2	3

지난 1주일 동안

0 = 전혀 없었거나 거의 없었다 (일주일에 1 일 미만)

1 = 간혹 있었다 (일주일에 1 - 2 일)

2 = 자주 있었다 (일주일에 3 - 4 일)

3 = 대부분 또는 거의 항상 있었다 (일주일에 5 - 7 일)

18. 슬프게 느껴졌다.	0	1	2	3
19. 사람들이 나를 싫어한다고 느꼈다.	0	1	2	3
20. 매사에 의욕이 없었다 .	0	1	2	3

* 다음은 배우자 (혹은 동거인)에 의한 신체적, 정서적 혹은 언어적 학대로 귀하가 가질 수 있는 심리적 혹은 신체적인 반응입니다. 귀하는 **지난 한 달 동안** 다음과 같은 증상 때문에 얼마나 괴로움을 느꼈다고 생각하십니까? 가장 적합한 번호에 O표 해주십시오

지난 한달 동안

1 = 전혀 괴롭지 않았다

2 = 약간 괴로웠다

3 = 어느정도 괴로웠다

4 = 상당히 괴로웠다

5 = 매우 괴로웠다

1. 학대받은 상황의 괴로운 기억이 자꾸 떠올라서	1	2	3	4	5
2. 학대받은 상황에 대한 악몽을 자꾸 꾸워서	1	2	3	4	5
3. 학대를 안받을 때도 학대받은 상황처럼 행동하거나 느껴서 (마치 그 때의 상황이 재현되는 것 같아서).	1	2	3	4	5
4. 학대받은 순간이 떠올랐을 때, 괴로운 심정 때문에	1	2	3	4	5
5. 학대받은 순간이 떠올랐을 때, 신체적인 반응 때 (예를들어, 심장이 뛰고, 숨이 가빠지고, 식은 땀이 나는 등) 때문에	1	2	3	4	5

지난 한달 동안

1 = 전혀 괴롭지 않았다

2 = 약간 괴로웠다

3 = 어느정도 괴로웠다

4 = 상당히 괴로웠다

5 = 매우 괴로웠다

6. 학대받은 상황에 대한 생각이나 대화를 꺼리고 그와 관련된 감정을 피하려고 해서	1	2	3	4	5
7. 학대를 떠오르게 하는 활동이나 상황을 피하려고 해서	1	2	3	4	5
8. 학대상황과 관련된 주요 부분이 잘 기억나지 않아서	1	2	3	4	5
9. 평상시 즐겼던 활동에 대해 흥미를 잃어서	1	2	3	4	5
10. 다른 사람들이 멀게 느껴져서	1	2	3	4	5
11. 가까웠던 사람들에 대해 애정을 가질 수 없거나 감정적으로 무감각해져서.	1	2	3	4	5
12. 미래가 없는것 같이 느껴져서	1	2	3	4	5
13. 잠들기가 쉽지 않거나 깊이 잠을 자지 못해서	1	2	3	4	5
14. 짜증스럽거나 화가 폭발할 것 같은 기분이 들어서	1	2	3	4	5
15. 집중하기가 어려워서	1	2	3	4	5
16. 지나치게 조심하고 경계심이 생겨서.	1	2	3	4	5
17. 과민하거나 잘 놀라서.	1	2	3	4	5

* 다음 각 문장 (1번 – 33번) 은 배우자의 폭력적 행동이나 태도를 묘사하고 있습니다. **지난 1년 동안** 귀하의 배우자 (혹은 동거인)는 귀하에게 얼마나 자주 다음과 같은 행동을 하였는지 가장 적합한 번호에 O표 해주십시오.

지난 1년동안

0 = 전혀 없었다

1 = 1 회

2 = 2 회

3 = 3-5 회

4 = 6-10 회

5 = 11-20 회

6 = 20 회 이상

7 = 과거 일년동안은 없었지만, 그전에는 있었다

1. 배우자가 나를 모욕하거나 욕을 했다.	0	1	2	3	4	5	6	7
2. 배우자가 나에게 소리를 지르거나 고함을 쳤다.	0	1	2	3	4	5	6	7
3. 나와 의견이 맞지 않을 때 배우자는 꽝꽝 거리는 발소리를 내며 방이나 집을 확 나가 버렸다.	0	1	2	3	4	5	6	7
4. 배우자가 나를 괴롭히기 위해 악의적인 말을 했다.	0	1	2	3	4	5	6	7
5. 배우자가 나를 뚱뚱하다거나 못생겼다고 말했다.	0	1	2	3	4	5	6	7
6. 배우자가 내 물건을 부셔 버렸다.	0	1	2	3	4	5	6	7
7. 배우자는 나를 "성적으로 전혀 만족스러운 상대가 아니다"라고 비난했다.	0	1	2	3	4	5	6	7
8. 배우자가 내게 물건을 집어던지거나 때릴 것처럼 위협했다.	0	1	2	3	4	5	6	7
9. 배우자가 다칠 수 있는 물건을 내게 집어 던졌다.	0	1	2	3	4	5	6	7
10. 배우자가 나의 팔을 비틀거나 머리카락을 잡아당겼다.	1	2	3	4	5	6	7	0

<u>지난 1년동안</u>

0 = 전혀 없었다

1 = 1 회

2 = 2 회

3 = 3-5 회

4 = 6-10 회

5 = 11-20 회

6 = 20 회 이상

7 = 과거 일년동안은 없었지만, 그전에는 있었다

11. 배우자가 나를 밀쳤다.	0	1	2	3	4	5	6	7
12. 배우자가 나를 꽉 움켜 잡았다.	0	1	2	3	4	5	6	7
13. 배우자가 내 뺨을 때렸다.	0	1	2	3	4	5	6	7
14. 배우자가 칼이나 총을 들이댔다.	0	1	2	3	4	5	6	7
15. 배우자가 다칠 수 있는 물건으로 나를 치거나 때렸다.	0	1	2	3	4	5	6	7
16. 배우자가 나의 목을 조였다.	0	1	2	3	4	5	6	7
17. 배우자가 벽으로 나를 심하게 밀쳤다.	0	1	2	3	4	5	6	7
18. 배우자가 나를 심하게 구타했다.	0	1	2	3	4	5	6	7
19. 배우자가 고의로 화상을 입히거나 살갗이 벗겨지는 상처를 입혔다.	0	1	2	3	4	5	6	7
20. 배우자가 나를 걷어 찼다.	0	1	2	3	4	5	6	7
21. 배우자가 콘돔을 사용하지 않은 체 섹스를 하도록 했다.	0	1	2	3	4	5	6	7
22. 배우자가 내가 원하지 않을 때 섹스를 강요했다 (그러나 물리적인 힘을 사용하지는 않았다).	0	1	2	3	4	5	6	7
23. 배우자가 오랄 섹스나 항문 섹스를 강요했다 (그러나 물리적인 힘을 사용하지는 않았다).	0	1	2	3	4	5	6	7

<u>지난 1년동안</u>

0 = 전혀 없었다

1 = 1 회

2 = 2 회

3 = 3 - 5 회

4 = 6 - 10 회

5 = 11 - 20 회

6 = 20 회 이상

7 = 과거 일년동안은 없었지만, 그전에는 있었다

24. 배우자가 강제로 (예: 때리거나, 강제적으로 눕히거나, 혹은 무기를 사용하는 등) 오랄 섹스나 항문 섹스를 하게 하였다.	0	1	2	3	4	5	6	7
25. 배우자가 강제로 (예: 때리거나, 강제적으로 눕히거나, 혹은 무기를 사용하는 등) 섹스를 하게 하였다.	0	1	2	3	4	5	6	7
26. 배우자가 나를 협박하여 오랄 섹스나 항문 섹스를 하게 하였다.	0	1	2	3	4	5	6	7
27. 배우자가 나를 협박하여 섹스를 하게 하였다.	0	1	2	3	4	5	6	7
28. 배우자와의 싸움으로 삐거나, 멍 들거나, 상처를 입었다.	0	1	2	3	4	5	6	7
29. 배우자와의 싸움으로 인한 상처로 인해 그 다음 날에도 여전히 아팠다.	0	1	2	3	4	5	6	7
30. 배우자와의 싸움 도중 머리를 맞아서 의식을 잃었다.	0	1	2	3	4	5	6	7
31. 배우자와의 싸움으로 인한 상처나 몸이 아파서 병원에 갔다.	0	1	2	3	4	5	6	7
32. 배우자와의 싸움으로 인한 상처나 신체적 아픔으로 병원에 가야 했지만 실제로 가지는 않았다.	0	1	2	3	4	5	6	7
33. 배우자와의 싸움으로 인해 뼈가 부러진 적이 있다.	0	1	2	3	4	5	6	7

* 다음 (1번 – 15번) 은 귀하의 대인관계에 대한 질문입니다. 가장 적합한 번호에 O표 해주십시오

1 = 매우 동의한다

2 = 어느정도 동의한다

3= 어느정도 동의하지 않는다

4= 매우 동의하지 않는다

1. 나의 문제를 해결하는 데 도움을 줄 수 있는, 믿을 만한 사람들이 나게는 있다.	1	2	3	4
2. 사적이고 비밀스러운 문제에 대해 편하게 애기 할 수 있는 사람이 내게는 전혀없다.	1	2	3	4
3. 내 문제에 대해 객관적으로 애기해 줄 수 있는 사람이 전혀 없다.	1	2	3	4
4. 내가 아파서 누군가 나를 병원에 데려가야 하는 상황이라면, 아마도 나를 도와줄 사람을 찾느라고 애를 먹을 것이다.	1	2	3	4
5. 만약 내가 위급한 상황으로 인해 일주일 정도 머무를 곳이 필요하다면, 내게 머무를 곳을 제공해 줄 사람을 쉽게 찾을 수 있을 것이다.	1	2	3	4
6. 사적인 걱정거리나 두려움을 이야기할 수 있는 사람이 내게는 아무도 없는 것 같다.	1	2	3	4
7. 내가 아플 때 나의 일상적인 일들을 도와 줄 사람을 쉽게 찾을 수 있을 것이다.	1	2	3	4
8. 나의 가족문제에 대해 조언을 구할 수 있는 사람이 내게는 있다.	1	2	3	4
9. 사적인 문제에 대해 제안이나 조언을 구할 수 있는 사람이 있다.	1	2	3	4
10. 내가 100 달러를 급히 빌려야 하는 상황일 때, 내게 그 정도의 돈을 빌려줄 수 있는 사람이 있다.	1	2	3	4
11. 내가 몇 주 정도 집을 비워야 한다면, 집을 봐 달라고 부탁할 사람을 찾기가 어려울 것이다.	1	2	3	4

1 = 매우 동의한다

2 = 어느정도 동의한다

3= 어느정도 동의하지 않는다

4= 매우 동의하지 않는다

12. 차를 몇 시간 정도 빌려줄 사람을 찾기가 어려울 것이다.	1	2	3	4
13. 정서적으로 유대감을 가진 사람이 적어도 한 명은 있다.	1	2	3	4
14. 나와 아주 친밀한 관계에 있는 사람이 적어도 한명은 있다.	1	2	3	4
15. 나에게 정서적인 안정을 주는 가까운 관계들이 있다.	1	2	3	4

* 다음 (1번 – 47번) 은 어떤 문제에 직면 했을때 해결 방법들에 대한 묘사입니다. 귀하는 <u>배우자로부터 신체적, 정서적 혹은 언어적 학대가 일어났을때, 그 문제를 다루는데</u> 다음과 같은 방법들을 얼마나 자주 사용하셨습니까? 가장 적합한 번호에 O표 해주십시오

0 = 한번도 사용한 적 없다

1 = 좀처럼 사용하지 않았다

2 = 때때로 사용했다

3 = 주로 혹은 정기적으로 사용했다

1. 벌어진 상황이 나의 탓이라고 생각했다.	0	1	2	3
2. 문제가 발생했을 때에도 긍정적인 면에 촛점을 두었다.	0	1	2	3
3. 나의 감정을 드러내지 않았다.	0	1	2	3
4. 내가 존경하는 사람에게 조언을 구하고 그 조언을 따랐다.	0	1	2	3
5. 나의 감정에 대해 누군가에게 이야기했다.	0	1	2	3

0 = 한번도 사용한 적 없다

1 = 좀처럼 사용하지 않았다

2 = 때때로 사용했다

3 = 주로 혹은 정기적으로 사용했다

6. 내 입장에서 내가 원하는 것을 위해 노력했다.	0	1	2	3
7. 나는 그 문제를 실제로 일어난 일이라고 믿으려 하지 않았다.	0	1	2	3
8. 나는 기적이 일어나기를 바랬다.	0	1	2	3
9. 나는 내 스스로를 비판하거나 훈계했다.	0	1	2	3
10. 문제를 해결하기 위해 여러 가지 다른 방법들을 생각해 보았다.	0	1	2	3
]11. 나는 내가 좀 더 강한 사람이었기를 바랬다.	0	1	2	3
12. 상황이 나아지도록 내 자신을 변화시켰다.	0	1	2	3
13. 타인의 이해나 공감을 받아들였다.	0	1	2	3
14. 평소 보다 더 많이 잤다.	0	1	2	3
15. 내 자신이 그러한 문제를 만들었다고 생각했다.	0	1	2	3
16. 상황을 피하지 못해 속상했다	0	1	2	3
17. 문제 해결을 위해 평소보다 두배로 노력했다.	0	1	2	3
18. 배우자에게 누군가로부터 도움을 받도록 제안했다.	0	1	2	3
19. 전화, 인터넷 등을 통해 유용한 정보나 도움 (경찰, 법률 서비스, 임시보호소[쉘터], 경제적 지원 등등)을 찾아 보았다.	0	1	2	3
20. 실제 보다 나은 상황을 상상하거나 공상했다.	0	1	2	3
21. 그 문제와 관련된 모든 것을 잊어 버리려고 했다.	0	1	2	3
22. 나는 전문가의 도움을 받았고 그들의 조언을 따랐다.	0	1	2	3

0 = 한번도 사용한 적 없다

1 = 좀처럼 사용하지 않았다

2 = 때때로 사용했다

3 = 주로 혹은 정기적으로 사용했다

23. 나는 긍정적인 방향으로 성장했다.	0	1	2	3
24. 격한 감정이 느껴졌어도 그것이 다른 일에 방해가 되지 않도록 조절하였다.	0	1	2	3
25. 마치 아무 일도 없었던 것 처럼 행동했다.	0	1	2	3
26. 나는 차선책이라도 그것을 받아 들였다.	0	1	2	3
27. 문제에 구체적인 도움을 줄 수 있는 사람과 이야기 했다.	0	1	2	3
28. 식사, 음주, 흡연, 약 복용 등을 통해 기분이 나아지도록 했다.	0	1	2	3
29. 나는 문제를 극단적으로 해결하지 않고 어떤 여지를 남겨 놓았다.	0	1	2	3
30. 성급하게 행동하거나 육감에 의존하지 않으려고 노력했다.	0	1	2	3
31. 일이 잘 되도록 하기 위해 무엇인가를 변화시켰다.	0	1	2	3
32. 사람들과 어울리게 되는 상황을 피했다.	0	1	2	3
33. 나는 차근 차근히 일을 진행했다.	0	1	2	3
34. 나의 상황이 얼마나 나쁜지에 대해 다른 사람에게 알리지 않았다.	0	1	2	3
35. 경험을 통해 전보다 배운것이 있다고 생각했다.	0	1	2	3
36. 문제에 대해 기도했다.	0	1	2	3
37. 문제에 대해 성직자 (목사님, 스님, 신부님 등) 에게 이야기했다.	0	1	2	3
38. 신념이나 신앙심을 가지고 그 상황을 이겨내기 위해 노력했다.	0	1	2	3
39. '이미 발생한 상황을 돌이킬 수 있었으면' 하고 바랬다.	0	1	2	3
40. 계획을 세워서 그것을 실천했다.	0	1	2	3
41. 나는 문제 상황을 명확히 이해하기 위해 다른 사람과 이야기 해 보았다.	0	1	2	3

0 = 한번도 사용한 적 없다

1 = 좀처럼 사용하지 않았다

2 = 때때로 사용했다

3 = 주로 혹은 정기적으로 사용했다

42. 문제 상황으로부터 긍정적인 것을 얻기 위해 양보하거나 협상하였다.	0	1	2	3
43. 문제를 회피했다.	0	1	2	3
44. "내가 느낀 것을 바꿀 수 있다면" 하고 바랬다.	0	1	2	3
45. 문제가 원하는데로 해결되는 환상이나 상상을 하였다.	0	1	2	3
46. 나는 문제 상황이 저절로 없어지거나 어떻게든 끝나기를 바랬다.	0	1	2	3
47. 나는 기분이 나아질 수 있는 비현실적인 생각 (완벽하게 복수를 갚는다던지 혹은 백만 달러를 발견한다던지) 을 했다.	0	1	2	3

* 다음(번호 1번 –5번)은 귀하의 신앙생활과 관련된 질문입니다. 가장 적합한 번호에 O표 해주십시오

1 = 매우 동의한다

2 = 동의한다

3 = 동의하지 않는다

4 = 매우 동의하지 않는다

1. 나는 매일 기도한다.	1	2	3	4
2. 나는 신앙을 통해 나의 삶의 의미와 목적을 찾는다.	1	2	3	4
3. 나는 신앙이나 종교에 있어 적극적이라고 생각한다.	1	2	3	4
4. 신앙이 같은 사람들과 어울리는 것을 좋아한다.	1	2	3	4
5. 신앙이 내 의사결정에 상당한 영향을 미친다.	1	2	3	4

* 다음 (번호 1번 –4번) 은 귀하가 <u>아동기 혹은 청소년기</u>에 다음과 같은 경험을 얼마나 하였는지를 묻는 질문입니다. 가장 적합한 번호에 O표 해주십시오

1 = 전혀 없었다

2 = 1 회

3 = 2 회 - 5 회

4 = 6 회 –10 회

5 = 10 회 이상 있었다

1. 아동기 혹은 청소년기에 성적으로 협박을 받은 적이 있다.	1	2	3	4	5
2. 아동기 혹은 청소년기에 원하지 않은 성적인 접촉을 당한적이 있다.	1	2	3	4	5
3. 아동기 혹은 청소년기에 누군가가 강제로 성관계를 시도한 적이 있다 (시도는 하였지만 관계를 맺지는 않았다: 강간 미수).	1	2	3	4	5
4. 아동기 혹은 청소년기에 누군가에 의해 강제로 성관계를 맺은 적이 있다 (강간).	1	2	3	4	5

* 다음 (번호 1-22) 은 귀하에 대한 일반적인 사항을 묻는 질문들 입니다.

1. 귀하는 언제 태어나셨습니까? 19___ 년 _____월

2. 귀하의 인종적 배경은 무엇입니까?

_____	백인	_____	한국인
_____	중국인	_____	베트남인
_____	기타 (구체적으로 _____)		

3. 귀하를 구타 및 학대한 적이 있는 남편 혹은 동거인과의 현재의 혼인 관계는 다음 중 어디에 해당합니까?

_____ 혼인상태 (기혼)이며 함께 살고 있다
_____ 혼인상태 (기혼)이나 별거 중
_____ 결혼하지 않은 상태에서 동거중
_____ 결혼하지 않은 상태에서 동거하였으나 현재는 별거 중
_____ 이혼 상태
_____ 기타 (구체적으로 _____)

4. 귀하는 귀하를 구타 및 학대한 적이 있는 남편 (동거인 혹은 남자친구) 과의 관계를 끝냈다고 생각하십니까?

_____ 아니오
_____ 예. 우리 두 사람의 관계는 끝났다고 생각한다

5. 가장 최근에 있었던 남편 (혹은 동거인이나 남자친구) 로부터의 구타 혹은 학대는 언제였습니까?

_____ 1주일 전
_____ 2주일 전
_____ 3주일 전
_____ 4주일 전
_____ 5주일- 8주일전 (2개월 전)
_____ 3개월 전
_____ 4개월 전
_____ 5개월 전
_____ 6개월 전
_____ 7개월 – 1 년전
_____ 그 이전

6.귀하는 귀하의 남편 (혹은 동거인이나 남자친구) 로부터 얼마나 오랬동안 구타 혹은 학대를 받았습니까 ?

약 _____ 년 _____ 개월

7. 귀하는 현재 쉘터에서 살고 있습니까?

_____ 그렇다 (문제 7-1로) _____ 아니다 (문제 8번으로)

7-1. 만약 귀하가 쉘터에서 살고 있다면, 얼마나 오랫동안 그곳에서 머물고 계십니까?

약 _____개월 _____ 일

8. 당신은 배우자의 학대의 문제가 내가 통제할 수 (변화시키기 위해 내가 무엇인가 할 수 있는) 있는 문제라고 생각하십니까?

_____ 예, 내가 통제할 수 있는 문제이다

_____ 아니다, 내 통제밖의 문제이다

9. 귀하의 자녀 중 현재 18세 이하의 자녀는 모두 몇 명입니까? _____ 명

10. 귀하의 현재 직업 상태는 무엇입니까? 해당하는 곳에 **모두** 표시하세요.

_____ 풀타임으로 고용
_____ 시간제 고용 (아르바이트 포함)
_____ 풀타임 학생
_____ 파트타임 학생
_____ 직장이 없다
_____ 전업주부
_____ 기타 _____

11. 귀하 가족의 일년 총 수입은 ?

_____ 10,000 불 이하
_____ 10,000 불에서 19,999 까지
_____ 20,000 불에서 29,999 까지
_____ 30,000 불에서 39,999 까지
_____ 40,000 불에서 49,999 까지
_____ 50,000 불에서 59,999 까지
_____ 60,000 불이상

12. 귀하의 최종 교육 수준은 무엇입니까?

무학	____						
초등학교	_____	1학년	_____	2학년	_____	3학년	
	_____	4학년	_____	5학년	_____	6학년	
중학교	_____	1학년	_____	2학년	_____	3학년	
고등학교	_____	1학년	_____	2학년	_____	3학년	
대학교	_____	1학년	_____	2학년	_____	3학년	_____ 4학년
대학 졸업	_____						
대학원 졸업	_____						
박사	_____						
기타	_____	(구체적으로 _____)					

13. 고등학교를 졸업 (혹은 검정고시로 인한 졸업) 하셨습니까?

예 _____ 아니오 _____

14. 귀하의 종교는?

_____	기독교	_____	힌두교
_____	불교	_____	이슬람교
_____	천주교	_____	종교 없음
_____	유교	_____	기타 (구체적으로 _____)

15. 종교적인 (혹은 초월적인 신을 믿는) 신념이 귀하의 일상생활에 얼마나 중요하게 간주됩니까?

_____	절대적으로 중요하다
_____	매우 중요하다
_____	중요하다
_____	약간 중요하다
_____	전혀 중요하지 않다

16. 귀하는 미국에서 태어나셨습니까?

_____	예 (17번으로)	_____	아니오 (16-1번으로)

16-1. 만약 귀하가 미국이 아닌 다른 나라에서 태어났다면, 귀하는 언제 처음 미국에 오셨습니까? _____ 년 _____ 월

16-2. 만약 귀하가 미국이 아닌 다른 나라에서 태어났다면, 귀하가 미국에서 산 기간은 총 몇 년 입니까? _____년

17. 어떤 언어를 사용하십니까?

_____ 한국말만 사용한다.
_____ 대부분 한국말을 사용하고 가끔 영어를 쓴다
_____ 한국말과 영어를 비슷한 정도로 사용한다.
_____ 대부분 영어를 사용하고 가끔 한국말을 쓴다.
_____ 영어만 사용한다
_____ 기타 다른 언어 사용 (_____)

18. 귀하는 귀하의 영어가 얼마나 유창하다고 생각하십니까?

_____ 전혀 유창하지 않다.
_____ 유창하지 않은 편이다.
_____ 보통이다.
_____ 유창하다.
_____ 매우 유창하다.

19. 귀하와 친하게 지내는 친구들은 누구입니까?

_____ 모두 한국인들이다.
_____ 대부분 한국인이고 몇몇은 미국인이다.
_____ 한국인 친구와 미국인 친구가 비슷한 정도로 있다
_____ 대부분 미국인 친구이고 몇몇이 한국인이다.
_____ 모두 미국인들이다.

20. 귀하는 주로 어떤 음식을 드십니까?

_____ 거의 항상 한국음식을 먹는다.
_____ 대체로 한국음식을 먹고 가끔 서양 음식을 먹는다.
_____ 한국 음식과 서양 음식을 먹는 경우가 비슷하다.
_____ 대부분 서양식을 먹고, 가끔 한국음식을 먹는다.
_____ 거의 항상 서양식을 먹는다.

21. 귀하가 주로 보는 TV/비디오는 무엇입니까?

_____ 거의 항상 한국 프로그램
_____ 대체로 한국 프로그램을 보고 가끔 미국 프로그램을 본다.
_____ 한국 프로그램과 미국 프로그램을 비슷한 정도로 본다.
_____ 대체로 미국 프로그램을 보고, 가끔 한국 프로그램을 본다.
_____ 거의 항상 미국 프로그램만 본다.

22. 귀하는 귀하자신을 어떻게 평가하시겠습니까?

_____ 매우 한국적이다.
_____ 대체로 한국적이다.
_____ 한국적이며 동시에 비슷한 정도로 미국적이다.
_____ 대체로 미국적이다.
_____ 매우 미국적이다.

대단히 감사합니다.

Appendix D

Chinese Version of Questionnaires

♣ 請在適當的數字打圈.這些數字代表的是你**在過去的一個星期中**有過多少次這樣的感受:

0 = 非常少或根本沒有過（少於一天）
1 = 很少有（一至二天）
2 = 有時候有（三至四天）
3 = 多半或總是有（五至七天）

1. 我被一些通常不會困擾我的事情困擾著	0	1	2	3
2. 我不想吃東西，我沒有胃口	0	1	2	3
3. 我感覺到雖然有家人和朋友的幫助 我還是不能拋開憂愁煩惱	0	1	2	3
4. 我覺得和別人比起來，我不比別人差	0	1	2	3
5. 我不能集中精神做一件事情	0	1	2	3
6. 我感到意志消沉	0	1	2	3
7. 我覺得我做每件事情都須要費力氣	0	1	2	3
8. 我對未來充滿希望	0	1	2	3
9. 我覺得我的一生是個失敗	0	1	2	3
10. 我感到害怕	0	1	2	3
11. 我睡不穩	0	1	2	3
12. 我感到快樂	0	1	2	3
13. 我比平常話說得少	0	1	2	3
14. 我感到孤獨	0	1	2	3
15. 人們是不友善的	0	1	2	3

在過去的一個星期中

0 = 非常少或根本沒有過（少於一天）

1 = 很少有（一至二天）

2 = 有時候有（三至四天）

3 = 多半或總是有（五至七天）

16. 我享受人生	0	1	2	3
17. 我有時想哭	0	1	2	3
18. 我感到悲傷	0	1	2	3
19. 我覺得人們不喜歡我	0	1	2	3
20. 我無法提起精神做事	0	1	2	3

♣ 因**為你**的另一半（包括配偶或同居人）對**你**的虐待，包括身體傷害、言語傷害、精神虐待或性侵害，在過去的一個月中，請依照**你**被下列的情形或問題所干擾的程度來回答一到十七的問題:

在過去的一個月中

1 = 根本沒有過

2 = 很少有

3 = 有時候有

4 = 多半有

5 = 非常多次或者總是有

1. 腦海中一再地反覆出現那些受到虐待的擾人回憶和景象	1	2	3	4	5
2. 重覆夢到遭受到虐待的擾人情景	1	2	3	4	5
3. 在沒有虐待發生的時候，突然間有受虐待的反應和感覺 （宛如自己又身歷其境一樣）	1	2	3	4	5

在過去的一個月中

1 = 根本沒有過

2 = 很少有

3 = 有時候有

4 = 多半有

5 = 非常多次或者總是有

4. 曾因為一些事情勾起受虐的記憶而感到非常煩悶	1	2	3	4	5
5. 曾因為外界一些事情而引發生理上的反應 （如心跳加速、呼吸困難、冒冷汗等）	1	2	3	4	5
6. 曾避免去想到或談起會讓你感到壓力的事件, 或去逃避自己那些跟受虐有關的感受	1	2	3	4	5
7. 避開那些會讓你聯想到受虐的活動跟情境	1	2	3	4	5
8. 曾回想不起來受虐事件的一些關鍵過程	1	2	3	4	5
9. 提不起勁去享受一些你以前可以享受的活動	1	2	3	4	5
10. 覺得跟其他人有距離或是跟人群疏遠	1	2	3	4	5
11. 覺得感情麻木或無法去關愛那些跟你親近的人	1	2	3	4	5
12. 覺得自己沒有什麼未來可言 （也就是察覺到自己沒有個長遠的計畫）	1	2	3	4	5
13. 難以入睡或是睡的很淺	1	2	3	4	5
14. 容易生氣或是大發脾氣暴怒	1	2	3	4	5
15. 無法集中精神	1	2	3	4	5
16. 精神非常警覺或是有警戒心	1	2	3	4	5
17. 覺得自己靜不下心或是很容易被驚嚇到	1	2	3	4	5

♣ 請仔細閱讀以下的句子（第一至第三十三題），並在一至七的數字中圈選適當的答案. <u>在過去的一年中，你</u>的另一半有過幾次這樣的行為:

0 = 從來沒有過
1 = 一次
2 = 二次
3 = 三至五次
4 = 六至十次
5 = 十一至二十次
6 = 二十次以上

7 = 過去的這一年沒有，但以前有發生過

1. 我的另一半對我口出穢言或罵髒話三字經	0	1	2	3	4	5	6	7
2. 我的另一半對我大吼大叫	0	1	2	3	4	5	6	7
3. 我的另一半在爭吵時衝到房門或屋子外頭去	0	1	2	3	4	5	6	7
4. 我的另一半用言語來貶低我	0	1	2	3	4	5	6	7
5. 我的另一半嫌我肥胖或嫌我醜	0	1	2	3	4	5	6	7
6. 我的另一半動手破壞屬於我的個人物品	0	1	2	3	4	5	6	7
7. 我的另一半說我是個差勁的情人	0	1	2	3	4	5	6	7
8. 我的另一半威脅說要動手打人或向我丟東西	0	1	2	3	4	5	6	7
9. 我的另一半向我丟些會讓人受傷的物品	0	1	2	3	4	5	6	7
10. 我的另一半扭我的手或抓我的頭髮	0	1	2	3	4	5	6	7
11. 我的另一半用力推我	0	1	2	3	4	5	6	7
12. 我的另一半抓著我	0	1	2	3	4	5	6	7
13. 我的另一半打我耳光	0	1	2	3	4	5	6	7
14. 我的另一半用刀或槍對著我	0	1	2	3	4	5	6	7
15. 我的另一半用會讓我受傷的東西打我	0	1	2	3	4	5	6	7
16. 我的另一半掐住我的喉嚨	0	1	2	3	4	5	6	7
17. 我的另一半把我打到牆邊	0	1	2	3	4	5	6	7
18. 我的另一半痛 / 毆打我	0	1	2	3	4	5	6	7

在過去的一年中

0 = 從來沒有過
1 = 一次
2 = 二次
3 = 三至五次
4 = 六至十次
5 = 十一至二十次
6 = 二十次以上

7 = 過去的這一年沒有，但以前有發生過

19. 我的另一半故意燙傷我或傷害我	0	1	2	3	4	5	6	7
20. 我的另一半踢我	0	1	2	3	4	5	6	7
21. 我的另一半不用保險套而強迫我性交	0	1	2	3	4	5	6	7
22. 我的另一半在我不想性交時堅持要（但並沒有用肢體暴力脅迫）	0	1	2	3	4	5	6	7
23. 我的另一半要跟我口交或肛交（但並沒有用肢體暴力脅迫）	0	1	2	3	4	5	6	7
24. 我的另一半用暴力脅迫要我口交或肛交（像是打人、硬抓著，或使用武器）	0	1	2	3	4	5	6	7
25. 我的另一半用暴力脅迫要我性交（像是打人、硬抓著，或使用武器）	0	1	2	3	4	5	6	7
26. 我的另一半使用威脅來要我口交或肛交	0	1	2	3	4	5	6	7
27. 我的另一半使用威脅來要我性交	0	1	2	3	4	5	6	7
28. 我身上有來自和另一半動手而造成的扭傷淤青或小傷口	0	1	2	3	4	5	6	7
29. 和另一半動手打架的隔天我還會覺得身體酸痛	0	1	2	3	4	5	6	7
30. 我被另一半打到頭部而昏過去	0	1	2	3	4	5	6	7
31. 我曾因另一半動手打架而去看醫生	0	1	2	3	4	5	6	7
32. 我因另一半動手打架的結果而需要就醫，但我卻沒有去	0	1	2	3	4	5	6	7
33. 我曾被另一半打斷骨頭	0	1	2	3	4	5	6	7

♣ 請依照**你**從其他人那裡得到的幫助程度來回答下列一至十五的問題:

1 = 非常同意　　2 = 有些同意　　3 = 有些不同意　　4 = 非常不同意

1. 我有幾個可以值得信賴並幫助我解決困難的人	1	2	3	4
2. 我沒有一個可以暢談心裡的問題和個人隱私的對象	1	2	3	4
3. 世界上沒有一個人能對我個人處理問題的方式提供客觀的意見	1	2	3	4
4. 我萬一生病而需要就醫時，我可能會找不到人來幫我	1	2	3	4
5. 萬一有警急事故而要找個臨時住處去住上一個星期，我會很容易找到願意收留我的人	1	2	3	4
6. 我覺得我找不到一個人來分擔我個人心靈深處的憂慮和害怕恐懼	1	2	3	4
7. 我萬一生病時，我可以很容易找到人來幫我處理一些日常瑣事	1	2	3	4
8. 我有一個可以詢求有關如何處理我家庭問題意見的對象	1	2	3	4
9. 當我需要他人意見和建議來解決我個人的問題時，我知道我可以找誰	1	2	3	4
10. 我如果需要一百元來急用，我知道我可以跟誰開口借	1	2	3	4
11. 我如果必須出城幾週，我可能很難找到人來幫我看房子或公寓	1	2	3	4
12. 我可能很難找到願意把車子借給我用幾個小時的人	1	2	3	4
13. 我覺得我最起碼有跟某一個人很貼心，心意很相連	1	2	3	4
14. 我有讓我心中覺得親密（或親近）的對象	1	2	3	4
15. 我擁有讓我感到情感安定和快樂的親密關係	1	2	3	4

♣ 下面的描述是有關**你**處理重大問題的可能方式. 當**你**的另一半虐待**你**的時候（包括身體傷害、言語傷害、精神虐待或性侵害）， **你**有多常以下列的作**為**或想法來面對問題？

0 = 從來沒有過

1 = 很少有過

2 = 有時候有

3 = 經常有

1. 我會**為**所發生的事情責怪自己	0	1	2	3
2. 我只專心去想從這整件事情中可能會發生的好的結果	0	1	2	3
3. 我把自己的感覺藏在心中	0	1	2	3
4. 我向我所尊重的人詢求意見並照著做	0	1	2	3
5. 我會告訴別人我心中的感覺	0	1	2	3
6. 我會堅定立場並**為**我想要的努力爭取	0	1	2	3
7. 我不願去相信**它**曾經發生過	0	1	2	3
8. 我希望有奇蹟出現	0	1	2	3
9. 我會自責或**教**訓自己	0	1	2	3
10. 我會想出幾個不同解決問題的辦法	0	1	2	3
11. 我希望我會是個更堅**強**的人	0	1	2	3
12. 我會改變自己的一些地方來更有效的處理問題	0	1	2	3
13. 我接受別人的同情和諒解	0	1	2	3
14. 我會睡的比平常多	0	1	2	3
15. 我知道我的問題都是我咎由自取	0	1	2	3
16. 我**為**自己逃不過問題而感到難過	0	1	2	3

0 = 從來沒有過

1 = 很少有過

2 = 有時候有

3 = 經常有

17. 我知道該怎麼做，所以會加倍努力來儘量讓對的事情發生	0	1	2	3
18. 我建議另一半向外尋求他人的協助	0	1	2	3
19. 我會透過電話簿或電腦網際網路等方式來找相關資 源或資訊（如警察局，法律服務，庇護所跟理財服務等）	0	1	2	3
20. 我會夢想讓自己處在一個不同於現況的更好的時空	0	1	2	3
21. 我試著把整件事情給忘記	0	1	2	3
22. 我會使用專業的協助並照著建議做	0	1	2	3
23. 我有成為一個好人或有好的改變	0	1	2	3
24. 我接納自己的強烈情緒但不讓它們過於干擾其他行事	0	1	2	3
25. 我假裝什麼都沒有發生過而繼續過日子	0	1	2	3
26. 我會退而求其次	0	1	2	3
27. 我和會處理事情的人討論問題	0	1	2	3
28. 我會靠著吃東西，喝酒，抽煙，用藥等來讓自己覺得好過	0	1	2	3
29. 我試著不過河拆橋，給自己留後路	0	1	2	3
30. 我試著不倉促就事或依直覺行事	0	1	2	3
31. 我會做些改變好讓事情好轉	0	1	2	3
32. 我大部分時間會避開和別人在一起	0	1	2	3

0 = 從來沒有過

1 = 很少有過

2 = 有時候有

3 = 經常有

33. 我只能是走一步算一步	0	1	2	3
34. 我不讓別人知道事情有多糟	0	1	2	3
35. 我從這經驗中讓自己變得更好	0	1	2	3
36. 我祈求老天保佑	0	1	2	3
37. 我跟師父／牧師／神父提到我的困境	0	1	2	3
38. 我靠著信仰支持我	0	1	2	3
39. 我希望我能改變過去所發生過的事	0	1	2	3
40. 我會做計畫並且照著實行	0	1	2	3
41. 我會跟人聊聊來幫助自己了解狀況	0	1	2	3
42. 我會跟人談判或妥協好讓自己得到點正面的結果	0	1	2	3
43. 我會逃避我的問題	0	1	2	3
44. 我希望我可以改變我心中的感覺	0	1	2	3
45. 我會幻想或冀望後來事情可能會有的結果	0	1	2	3
46. 我希望事情會就過去或不會再發生	0	1	2	3
47. 我會突發奇想到一些不**真**實的事情，像是完美的復仇或是自己有一百萬元，來讓自己覺得心中好過	0	1	2	3

♣ 下列的五個問題是有關**你**的宗**教**信仰. 請依照以下的量表來回答**你**同意（或不同意）的程度 :

1 = 非常同意
2 = 不同意
3 = 同意
4 = 非常不同意

1. 我每天祈禱禱告	1	2	3	4
2. 我的信仰給我生命的意義和目的	1	2	3	4
3. 我認**為**我自己對於宗**教**活動很投入	1	2	3	4
4. 我喜歡和跟我有相同信仰的人**為**伍	1	2	3	4
5. 我的信仰對我的種種決定有相當的影響	1	2	3	4

♣ 下列四個題目是有關**你**的兒童及**青**少年時期的受虐經歷. 請依照**你**個人經歷該事件的次數, 從一至五的數字中圈選適當的答案:

1 = 從來沒有過
2 = 一次
3 = 二至五次
4 = 六至十次
5 = 十次以上

1. 在**你**小時候或**青**少年時, 有沒有人恐嚇過要對**你**進行性侵犯？	1	2	3	4	5
2. 在**你**小時候或**青**少年時, 有沒有人在**你**不情願下對**你**毛手毛腳？	1	2	3	4	5
3. 在**你**小時候或**青**少年時, 有沒有人試著要**強**迫**你**性交？（意圖**強**暴）	1	2	3	4	5
4. 在**你**小時候或**青**少年時, 有沒有人迫使**你**性交？（**強**暴）	1	2	3	4	5

基本資料

♣ 下列第一題至第二十三題是有關**你**個人的一般資料.

1. **你**在西元那一年出生？ 19____年

2. **你**的種族背景是？

_____美國白人　　_____韓裔人
_____華裔人　　_____越南裔人
_____其他（請說明_____）

3. **你**跟對**你**施暴的另一半的關係是？
_____ 住在一起的法定配偶
_____ 分居中的法定配偶
_____已離婚
_____ 同居，但沒有結婚
_____ 沒有結婚的分居
_____其他（請說明_____）

4. **你**覺得**你**已經把這段關係結束了**嗎**？
_____ 是　　_____ 不是

5. 最近的一次的虐待（包括身體傷害、言語傷害、精神虐待或性侵害）是何時發生的？

_____ 一週前
_____ 兩週前
_____ 三週前
_____ 四週前
_____ 五至八週前（兩個月前）
_____ 三個月前
_____ 四個月前
_____ 五個月前
_____ 六個月前
_____ 半年以上

6. **你**和這個人（對**你**施暴的另一半）在一起多久了？
有_____年_____個月了

7. **你**現在住在庇護所**嗎**？

_____是　　_____不是

7-1. 如果**你**現在是住在庇護所裡，**你**在這庇護所裡已經住多久了呢？ ___天 ___ 個月

8. **你**覺得**你**可以控制**你**另一半的施暴行**為嗎**？

_____ 是,　　_____ 不是

9. **你**有幾個未成年（未滿十八歲）的子女跟**你**同住？ _____ 個

10. **你**現在的就業狀況是？（可複選）

_____有全職的工作　　_____ 家管
_____有兼職的工作　　_____ 退休
_____全職學生　　_____其他（請說明_____）
_____兼職學生
_____ 無業，沒有工作

11. **你**的最高學歷是？

_____小學一年級　_____小學二年級　_____小學三年級
_____小學四年級　_____小學五年級　_____小學六年級
_____中學七年級　_____中學八年級　_____中學九年級
_____中學十年級　_____中學十一年級　_____中學十二年級
大學　_____ 大一　_____大二　_____大三　_____大四
_____ 學士學位
_____ 碩士學位
_____博士學位 （法律博士 JD，醫學博士 MD，哲學博士 Ph.D.）
_____ 其他

12. **你**有高中畢業證書或是同等學力證明資格**嗎**？

_____ 有高中畢業證書
_____ 高中同等學力證明資格
_____ 沒有

13. 你的家庭年度總收入有多少？

_____ 不到一萬元
_____ 一萬元到一萬九千九百九十九元之間
_____兩萬元到兩萬九千九百九十九元之間
_____三萬元到三萬九千九百九十九元之間
_____四萬元到四萬九千九百九十九元之間
_____五萬元到五萬九千九百九十九元之間
_____ 六萬元或六萬元以上

14. 你的宗教信仰是？

_____基督教　　_____ 伊斯蘭教
_____ 天主教　　_____ 孔孟儒家思想
_____ 佛教　　_____ 沒有信教
_____ 印度教　　_____其他（請說明_____）

15. 宗教或信仰在你的日常生活中有多重要？

_____ 極度重要
_____ 非常重要
_____ 適度重要
_____ 有點重要
_____ 一點都不重要

16. 你是在美國出生的嗎？

_____是 （請跳答至 17 題）
_____不是 （請續答 16-1 題）

16-1. 如果不是的話，你第一次來美國時是幾歲？

_____ 歲

16-2. 你已經在美國幾年了？

_____年_____個月了

17. 你用什麼語言？

_____ 只會說中文
_____ 大多是中文，說一點英文
_____ 中英文各半
_____ 大多是英文，說一點中文
_____ 只說英文

18. 你自認你的英文程度如何？

_____ 很差
_____ 不太好
_____ 尚可
_____ 不錯
_____ 很好

19. 你的好朋友有哪些？

_____ 只有華人
_____ 大部分是華人，也有一些美國人
_____ 華人美國人各半
_____ 大部分是美國人，也有一些華人
_____ 只有美國人

20. 你偏好的飲食是？

_____幾乎都是中式食物
_____大部分是中式食物，也吃一些美式的食物
_____ 中西式各半
_____ 大部分是美式食物，也吃一些中式食物
_____ 只吃美式食物

21. 你看電視／錄影帶的偏好是？

_____ 幾乎都只看中文節目
_____ 大部分看中文節目，也看一些美國節目
_____ 中文節目跟美國節目各看一半
_____大部分看美國節目，也看一些中文節目
_____只看美國節目

22. 你認為自己像是什麼人？

_____ 很中國人
_____ 較偏中國人
_____ 雙重文化（中國和美國各半）
_____ 較偏美國人
_____很美國人

多謝你的合作!

Appendix E

Vietnamese Version of Questionnaires

Dùng cân số (0 đến 3) dưới đây, cho biết chỉ số nào diễn tả đúng tâm trạng hay là hành vi của bạn trong suốt tuần qua

Trong suốt tuần vừa qua

0 = Hiếm hoặc không có lần nào (ít hơn 1 ngày)
1 = Một hoặc hai lần (1 đến 2 ngày)
2 = Thỉnh thoảng hoặc vài ba lần (3 đến 4 ngày)
3 = Thường xuyên hay nhiều lần (5 đến 7 ngày)

1. Tôi đã không bận tâm bởi nhưng việc mà thong thường không đáng kể đối với tôi	0	1	2	3
2. Tôi không cảm thấy muốn ăn	0	1	2	3
3. Tôi cảm thấy rằng tôi không thể dứt bỏ được sự buồn bả mặc dù gia bạn bè và gia đình giúp đỡ	0	1	2	3
4. Tôi đã cảm thấy rằng mình cũng giỏi như người khác	0	1	2	3
5. Tôi đã cảm thấy khó tập trung tinh thần vào lúc làm việc	0	1	2	3
6. Tôi đã cảm thấy chán nản	0	1	2	3
7. Tôi đã cảm thấy rằng tất cả những gì tôi làm đều bằng sự cố gắng	0	1	2	3
8. Tôi đã hy vọng nhiều về tương lai	0	1	2	3
9. Tôi đã nghĩ cuộc đời tôi là một sự thất bại	0	1	2	3
10. Tôi đã cảm thấy lo sợ	0	1	2	3
11. Tôi đã bị mất ngũ	0	1	2	3
12. Tôi đã cảm thấy sung sướng	0	1	2	3
13. Tôi đã ít nói hơn bình thường	0	1	2	3
14. Tôi đã cảm thấy cô đơn	0	1	2	3
15. Mọi người không thân thiện với tôi	0	1	2	3
16. Tôi đã cảm thấy yêu đời	0	1	2	3
17. Tôi đã bị suy nhược tinh thần	0	1	2	3

18. Tôi không cảm thấy buồn	0	1	2	3
19. Nhường như mọi người không thích tôi	0	1	2	3
20. Tôi không cảm thấy lười biếng	0	1	2	3

Dưới đây (câu hỏi #1 - 17) là bản liệt kê những vấn đề và lời than phiền mà con người thường hay phản ứng khi gặp phải những tình huống nan giải từ kết qủa của những lần chưi bới đáng đập hay là cương bứt bơi người phối ngẫu, bạn hãy chọn một trong những chỉ số dưới đây để mô tả cương độ phiền muộn của bạn trong suốt tháng vừa qua

Trong suốt tháng vừa qua

1 = Chưa bao giờ xảy ra
2 = Chút ít
3 = Vài ba lần
4 = Hơi nhiều lần
5 = Qúa nhiều lần

1. Những ám ảnh của sự bạo hành đã lập đi lập lại trong ký ức	1	2	3	4	5
2. Những cơn ác mộng về sự bạo hành cứ lập đi lập lại	1	2	3	4	5
3. Hành đông hay cảm giác đột ngột giống như là sự bạo hành đang xảy ra	1	2	3	4	5
4. Cảm thấy bực tức khi một chuyện gì gợi nhớ đến sự bạo hành	1	2	3	4	5
5. Có những phản ứng trong cơ thể (chẳng hạn như tim đập mạnh, khó thở, đổ mồ hôi) một khi chuyện gì gợi nhớ đến sự bạo hành	1	2	3	4	5
6. Tránh suy nghĩ hoặc nói đến sự bạo hành hay tránh những cảm xúc liên quan đến sự bạo hành	1	2	3	4	5
7. Tránh nhữnh sinh hoạt hay địa thế mà có thể làm cho bạn gợi nhớ đến sự bạo hành	1	2	3	4	5
8. Khó có thể nhớ lại yếu tố quan trọng của những lần bạo hành	1	2	3	4	5
9. Không có hứng thú trong những hoạt động mà bạn đã thích trước đây	1	2	3	4	5
10. Cảm thấy xa lánh vớI moị người	1	2	3	4	5
11. Thấy lãnh cảm hay không có cảm giác yêu thương với những người thân cận	1	2	3	4	5

12. Cảm thấy tương lai ngắn ngủi	1	2	3	4	5
13.Khó ngũ hoặc mất ngũ	1	2	3	4	5
14. Cảm thấy giận giữ	1	2	3	4	5
15. Không thể tập trung	1	2	3	4	5
16. Trở nên qúa cẩn thận	1	2	3	4	5
17. Dễ bị sợ hãi	1	2	3	4	5

Xin đọc những câu hỏi dưới đây (từ 1 đến 33) và khoanh tròn số tương xứng, từ 1 đến 7 để mô tả kỷ càng bao nhiêu lần người phối ngẫu đã có những hành vi như được hỏi dưới đây
Trong suốt một năm vừa qua

0 = Chưa bao giờ
1 = 1 lần
2 = 2 lần
3 = 3 - 5 lần
4 = 6 -10 lần
5 = 11 - 20 lần
6 = Nhiều hơn 20 lần
7 = Không có xảy ra năm ngoái, nhưng có xảy ra trước đây

1. Người phối ngẫu đã lăng mạ hay nguyền rủa tôi	0	1	2	3	4	5	6	7
2. Người phối ngẫu đã la hét hay chửi mắng tôi	0	1	2	3	4	5	6	7
3. Người phối ngẫu bỏ đi ra khỏi phòng, nhà hay vườn trong khi gây gỗ	0	1	2	3	4	5	6	7
4. Người phối ngẫu đã có điều xúc phạm đến tôi	0	1	2	3	4	5	6	7
5. Người phối ngẫu đã goị tôi mập hay xấu	0	1	2	3	4	5	6	7
6. Người phối ngẫu hủy hoại đồ dùng của tôi	0	1	2	3	4	5	6	7

0 = Chưa bao giờ
1 = 1 lần
2 = 2 lần
3 = 3 - 5 lần
4 = 6 -10 lần
5 = 11 - 20 lần
6 = Nhiều hơn 20 lần
7 = Không có xảy ra năm ngoái, nhưng có xảy ra trước đây

7. Người phối ngẫu đã buộc tộI tôi là một ngườI tình rất tồi	0	1	2	3	4	5	6	7
8. Người phối ngẫu đã doạ đánh đập hay ném đồ vật vào tôi	0	1	2	3	4	5	6	7
9. Người phối ngẫu đã ném đồ vật vào tôi mà có thể gây thương tích	0	1	2	3	4	5	6	7
10. Người phối ngẫu đã vặn tay hay lôi tóc tôi	0	1	2	3	4	5	6	7
11. Người phối ngẫu đã xô đẩy tôi	0	1	2	3	4	5	6	7
12. Người phối ngẫu đã chop lấy tôi	0	1	2	3	4	5	6	7
13. Người phối ngẫu đã tát vào mặt tôi	0	1	2	3	4	5	6	7
14. Người phối ngẫu đã chiã dao và sung vào ngườI của tôi	0	1	2	3	4	5	6	7
15. Người phối ngẫu đã đấm và đánh tôi mà có thể gây thương tích	0	1	2	3	4	5	6	7
16. Người phối ngẫu đã bóp cổ tôi	0	1	2	3	4	5	6	7
17. Người phối ngẫu đã ném tôi vào tường	0	1	2	3	4	5	6	7
18. Người phối ngẫu đã đánh đập tôi túi buị	0	1	2	3	4	5	6	7
19. Người phối ngẫu đã đốt hay cào cấu tôi	0	1	2	3	4	5	6	7
20. Người phối ngẫu đã đá tôi	0	1	2	3	4	5	6	7
21. Người phối ngẫu đã bắt tôi giao hợp mà không dùng bao cao su	0	1	2	3	4	5	6	7
22. Người phối ngẫu đã nài nỉ tôi làm tình khi tôi không muốn (nhưng không dung vũ lực)	0	1	2	3	4	5	6	7

0 = Chưa bao giờ
1 = 1 lần
2 = 2 lần
3 = 3 - 5 lần
4 = 6 -10 lần
5 = 11 - 20 lần
6 = Nhiều hơn 20 lần
7 = Không có xảy ra năm ngoái, nhưng có xảy ra trước đây

23. Người phối ngẫu đã nài nỉ tôi làm tình bằng miệng và hậu môn (nhưng không dung vũ lực)	0	1	2	3	4	5	6	7
24. Người phối ngẫu đã dùng vũ lực (như là đáng đập, vật nằm xuống, hay dùng vũ khí) để bắt tôi làm tình bằng miệng và hậu môn	0	1	2	3	4	5	6	7
25. Người phối ngẫu đã dùng vũ lực (như là đáng đập, đè nằm xuống, hay dùng vũ khí) để bắt tôi làm tình	0	1	2	3	4	5	6	7
26. Người phối ngẫu đã đe doạ để bắt buộc tôi làm tình bằng miệng và hậu môn	0	1	2	3	4	5	6	7
27. Người phối ngẫu đã đe doạ để bắt buộc tôi làm tình	0	1	2	3	4	5	6	7
28. Tôi đã bị trặc, bầm tím, hay bị trầy truạ vì xô xát vơí người phối ngẫu	0	1	2	3	4	5	6	7
29. Tôi đã cảm thấy cơ thể đau nhức vào ngày hôm sau vì đã xô xát vơí ngườI phốI ngẫu	0	1	2	3	4	5	6	7
30. Tôi đã bị bất tĩnh khi bị người phối ngẫu đánh vào đầu trong lúc xô xát	0	1	2	3	4	5	6	7
31. Tôi đã đi khám Bác Sĩ vì đã xô xát vơí người phối ngẫu	0	1	2	3	4	5	6	7
32. Đúng ra tôi phaỉ cần đi khám Bác Sĩ vì đã xô xát vơí người phối ngẫu, nhưng tôi đã không đi	0	1	2	3	4	5	6	7
33. Tôi đã bị gãy xương trong lúc xô xát	0	1	2	3	4	5	6	7

Xin trả lời những câu hỏi (1 -15) dưới đây liên quan đến những sự giúp đỡ mà bạn nhận được từ những người khác

1 = Đồng ý hòan toàn
2 = Đồng ý phần nào
3 = Không đồng ý phần nào
4 = Hòan toàn không đồng ý

1 Có vài người mà tôi tin tưởng, họ có thể giúp đỡ tôi giaỉ quyết vấn đề	1	2	3	4
2. Không có ai mà tôi cảm thấy thoải mái để nói chuyện sâu sắc về vấn đề riêng tư của tôi	1	2	3	4
3. Không có ai có thể cho tôi một cái nhình khách quan về cách tôi hành sự những vấn đề riêng tư của tôi	1	2	3	4
4. Nếu tôi đau mà cần đưa đi Bác Sĩ, tôi khó kiếm được mgười giúp	1	2	3	4
5. Nếu tôi cần một chổ cho 1 tuần vì sự cấp bách, tôi có thể kiếm 1 ngươi sẵn sàng cho tôi ở nhờ	1	2	3	4
6. Tôi cảm thấy không có người nào mà tôi có thể tâm sự về sự lo lắng và sợ hãi của tôi	1	2	3	4
7. Nếu tôi đau ốm tôi có thể dễ dàng kiếm 1 người giúp tôi làm công việc hàng ngày của tôi	1	2	3	4
8. Có một vài người tôi có thể nói chuyện để họ cố vấn tôi về việc hành sự những vấn đề của gia đình	1	2	3	4
9. Khi tôi cần những ý kiến đề nghi cách hành sự về vấn đề riêng tư, tôi biết một vài ngườI mà tôi có thể gặp và thăm hỏi	1	2	3	4
10. Nếu tôi cần mượn $100, tôi biết một vài ngườI có thể cho tôi vay	1	2	3	4
11. Nếu tôi phải đi xa trong vài tuần, chắc không dễ kiếm 1 người trông nom nhà tôi	1	2	3	4
12. Chắc khó có thể kiếm được một ngườI cho tôi mượn xe trong 1 vài giờ	1	2	3	4
13. Tôi cảm thấy tâm đầu ý hợp với ít nhất 1 người	1	2	3	4
14. Tôi cảm thấy gần gũi với một người	1	2	3	4
15. Tôi có những liên hệ mật thiết mà có thể cung cấp cho tôi một cảm gíac an toàn và hạnh phúc	1	2	3	4

Những câu hỏi dướI đây (1 - 47) tiêu biểu cho những phương thức mà bạn có thể dung để đối phó với những vấn đề quan trọng. Khi người phối ngẫu dung bạo hành, bao nhiêu lần bạn đã dùng lối suy nghĩ/cách xử sự dưới đây đê/ đối phó với vấn đề?

0 = Chưa bao giờ
1 = Hiếm khi dung
2 = Thỉnh thoảng có dung
3 = Thường hay dung đến

1. Tôi tự trách mình về những gì đã xảy ra	0	1	2	3
2. Tôi đã chú trọng vào những khía cạnh tốt mà có thể xẩy ra từ toàn sự việc	0	1	2	3
3. Tôi giữ kín cảm xúx của tôi	0	1	2	3
4. Tôi đã nói chuyện với một vài người mà tôi kính phục và làm theo lời khuyên của họ	0	1	2	3
5. Tôi đã nói chuyện với một vài ngươi về cảm xúx của tôi lúc đó	0	1	2	3
6. Tôi đã giữ vững lập trường và tranh đấu cho những gì tôi muốn	0	1	2	3
7. Tôi không muốn tin vào những điều đã thực sự xảy ra	0	1	2	3
8. Tôi hy vọng cho một sự mầu nhiệm xảy ra	0	1	2	3
9. Tôi tự trách móc mình	0	1	2	3
10. Tôi đã nãy sinh ra vài phương thức khác nhau để giải quyết vấn đề	0	1	2	3
11. Tôi mong ước tôi là một người mạnh dạn hơn	0	1	2	3
12. Tôi tự thay đổi chính mình để có thể giải quyết vấn đề tốt đẹp hơn	0	1	2	3
13. Tôi đã chấp nhận sự thương xót và thông cảm của một vài người	0	1	2	3
14. Tôi ngũ nhiều hơn bình thường	0	1	2	3
15. Tôi đã nhận thức rằng tôi đã tự đem vấn đề đến cho chính tôi	0	1	2	3
16. Tôi cảm thấy buồn vì đã không tránh được vấn đề	0	1	2	3

0 = Chưa bao giờ
1 = Hiếm khi dung
2 = Thỉnh thoảng có dung
3 = Thường hay dung đến

17. Tôi biết điều cần phải làm cho nên tôi đã cố gắng gấp đôi và thử nhiều hơn để làm cho vấn đề tốt đẹp hơn	0	1	2	3
18. Tôi đã đưa ý kiến cho ngườI phốI ngẫu để tìm sự giúp đỡ	0	1	2	3
19.Tôi đa~ kiếm tài liệu và phương cách (như cảnh sát dịch vụ luật pháp, nhà trọ, dịch vụ tài chánh) qua sổ niên giám điện thoại, mạng lưới điện vân, vân	0	1	2	3
20. Tôi đã mơ hay tưởng tượng một thời gian hay nơi chốn tốt hơn chỗ tôi đang ở bây giờ	0	1	2	3
21. Tôi đã thử để quên đi mọi chuyện	0	1	2	3
22. Tôi đã được sự giúp đỡ của chuyên gia và đã làm những gì họ khuyên	0	1	2	3
23. Tôi đã thay đổI hay lớn lên trong một lối sống tốt	0	1	2	3
24. Tôi chấp nhận những cảm nhận vững chắc của tôi, nhưng không thể cho nó ảnh hưởng	0	1	2	3
25. Tôi tiếp tục sống như không có gì xảy ra	0	1	2	3
26. Tôi chấp những điều gần tốt như tôi đã mong muốn	0	1	2	3
27. Tôi đã nói chuyện vớ những người mà họ có thể giải quyết vấn đề ổn thoả	0	1	2	3
28. Tôi cảm thấy mệt mõi vì cách ăn uống, hút thuốc, uống thuốc để kích động tinh thần	0	1	2	3
29. Tôi không muốn xóa bỏ những gì đã đi qua, nhưng chỉ để hé mở 1 chút thôi	0	1	2	3
30. Tôi tránh hành động vộI vàng hay theo linh cảm	0	1	2	3
31. Tôi đã thay đổi một vài điều để cho công việc trở nên đúng	0	1	2	3

0 = Chưa bao giờ
1 = Hiếm khi dung
2 = Thỉnh thoảng có dung
3 = Thường hay dung đến

32. Tôi tránh gặp moị người	0	1	2	3
33. Tôi chỉ giãi quyết công việc từng bước một	0	1	2	3
34. Tôi không để cho người khác biết dù việc xấu đến đâu	0	1	2	3
35. Tôi cảm thấy nhẹ nhõm sau khi vấn đề đã xảy ra hơn là khi tôi gặp phải vấn đề	0	1	2	3
36. Tôi đã cầu nguyện	0	1	2	3
37. Tôi đã nói chuyện vớI mục sư về hoàn cảnh của tôi	0	1	2	3
38. Tôi đã nương tựa vào niềm tin để đưa tôi qua những khó khăn	0	1	2	3
39. Tôi ước tôi đã có thể thay đổi được tình huống	0	1	2	3
40. Tôi đã hooch định kế hooch hành động và thoe đó mà tiến hành	0	1	2	3
41. Tôi đã nói chuyện vớI vaì ngườI để tìm hiểu về tình trạng của vấn đề	0	1	2	3
42. Tôi mặc cả hay thương lượng cho hòan cảnh trở nên tốt hơn	0	1	2	3
43. Tôi đã trốn tránh những vấn đề của tôi	0	1	2	3
44. Tôi ước rằng tôi có thể thay đổI được phương cách ma ` tôi đã cảm nhận	0	1	2	3
45. Tôi đã có những ý nghĩ kỳ quặc hay mơ tưởng về những tình huống mà ự việc có thể thay đổi	0	1	2	3
46. Tôi ước ti1nh trạng có thể biến mất đi hay kết thúc bằng cách này hay cách khác	0	1	2	3
47. Tôi đã nghĩ về những sự việc kỳ quaí, không hiện thực như một cách trả thù hoàn hảo hay tìm thấy 1 triệu dồng để cho tôi cảm thấy sung sướng hơn	0	1	2	3

Xin trả lời những câu hỏi dưới đây (1-5) liên quan đến niềm tin tôn giáo bằng cách chọn một trong những chỉ số bên dưới

1 = Đồng ý hoàn toàn
2 = Đồng ý phần nào
3 = Không đồng ý phần nào
4 = Hoàn toàn không đồng ý

1. Tôi cầu nguyện hàng ngày	1	2	3	4
2. Tôi dựa vào niềm tin như là cứu cánh của cuộc đời tôi	1	2	3	4
3. Tôi xem tôi là người ngoan đạo và thích làm việc công qủa	1	2	3	4
4. Tôi thích sinh hoạt hay gần gủi với những ngườI có cùng niềm tin như tôi	1	2	3	4
5. Niềm tin có ảnh hưởng đến nhiều quyết định	1	2	3	4

Những câu hỏi dưới đây (1-4) liên quan đến những lạm dụng tình dục lúc còn thơ ấu và khi mới lớn. Chọn một trong những chỉ số dưới đây để trả lời cho bao nhiêu lần chuyện này đã xảy ra với bạn

1= Chưa bao giờ xảy ra
2 = Xảy ra 1 lần
3 = Xảy ra 2-5 lần
4 = Xảy ra 6-10 lần
5 = Xảy ra nhiều hơn 10 lần

1. Đã có ai đe dọa tình dục với bạn lúc còn thơ ấu hay khi mới lớn	1	2	3	4	5
2. Đã có ai sờ mó lạm dụng tình dục khi bạn không muốn trong suốt thơì thơ ấu hay khi mới lớn	1	2	3	4	5
3. Đã có ai dung vũ lđể ép bạn giao hợp lúc còn thơ ấu hay khi mới lớn	1	2	3	4	5
4. Đã có ai cưỡng hiếp bạn trong thơ ấu hay khi mới lớn	1	2	3	4	5

Lý lịch

Những câu hỏi dưới đây (1-22) liên quan đến lý lịch tổng qúat của bạn

1 Bạn sinh năm nào? 19_____ năm

2. Bạn thuộc sắc tộc nào?

☐ Người Mỹ da trắng ☐ Đại Hàn lai Mỹ
☐ Người Tàu lai Mỹ ☐ Việt lai Mỹ
☐ Ngọai lệ

3. Tình trạng hôn nhân của bạn với người phối ngẫu bạo hành?

☐ Thành hôn - chung sống với nhau
☐ Thành hôn - không chung sống với nhau
☐ Ly dị
☐ Chưa thành hôn - không chung sống với nhau
☐ Chưa bao giờ thành hôn và không chung sống với nhau
☐Ngọai lệ

4. Bạn có cảm thấy muốn rời bỏ Người phối ngâũ bạo hành ?

☐Có ☐ Không

5. Khi nào thì lần bạo hành cuối cùng xảy ra?

☐ 1 tuần trước
☐ 2 tuần trước
☐ 3 tuần trước
☐ 4 tuần trước
☐ 5-8 tuần trước
☐ 3 tháng trước
☐ 4 tháng trước
☐ 5 tháng trước
☐ 6 tháng trước
☐ Hơn 6 tháng trước

6. Bạn đã hay đang ở trong quan hệ bạo hành này bao nhiêu lâu?

_____ năm _____ tháng _____ngày

7. Có phải bạn đang tạm trú tại trung tâm bảo vệ trong lúc này?

☐ có - nếu có, Bạn đã ở từ bao lâu? ____ ngày _____ tháng
☐ không

8. Bạn có cảm thấy rằng bạn có thể điều khiển được sự bạo hành của người phối ngẫu?

☐ có ☐ không

9. Bạn có bao nhiêu trẻ con (dưới 18 tuổi) đang ở với bạn? _____

10. Tình trong công việc làm của bạn ra sao?

☐ làm việc full time ☐ Nội trợ
☐ làm việc part time ☐ Về hưu
☐ Đi học full time ☐ Ngoại lệ
☐ Đi học part time
☐ Không có việc làm

11. Bạn đã học xong lớp mấy ở phổ thong hay học xong đại học năm thứ mấy?

Bậc trung học

☐ 00 ☐ 01 ☐02 ☐ 03 ☐04 ☐05
☐ 06 ☐ 07 ☐08 ☐ 09 ☐10 ☐11
☐ 12

Năm ở đại học

☐ 00 ☐ 01 ☐02 ☐ 03 ☐04
☐ Bằng cử nhân
☐ Bằng cao học
☐ Bằng chuyên nghiệp (luật, cao học thương mại, bác sĩ, tiến sĩ)
☐ Ngoại lệ

12. Bạn có bằng trung học hay tương đương hay không?

☐ có bằng trung học
☐ có bằng tương đương (GED)
☐ không

13. Lợi tức hàng năm của gia đình bạn là bao nhiêu?

☐ DướI $10,000
☐ $10,000 -19,999
☐ $20,000 - 29,999
☐ $30,000 -39,999
☐ $40,000 -49,999
☐ $50,000 -59,999
☐ Trên $60,000

14. Tôn giáo của bạn là gì?

☐ Cơ Đốc ☐ Hồi giáo
☐ Công Giáo ☐ Nho Giáo
☐ Phật Giáo ☐ Không Tôn giáo
☐ Ấn đô giáo ☐ Ngoại lệ

15. Tôn giáo hay tâm linh trong đời sống hàng ngày của bạn quan trọng như thế nào?

☐ Rất là quan trọng
☐ Quan trọng
☐ HơI quan trọng
☐ Chút ít quan trọng
☐ Không quan trọng gì cả

16. Bạn đã sinh ra ở Mỹ?

☐ Có
☐ Không
Nếu không, bạn đã bao nhiêu tuổi khi đến Mỹ _____ tuổi
Bạn đã ở Mỹ cho đến nay là bao nhiêu lâu ? _____ năm _____ tháng

17. Ngôn ngữ chính của bạn?

☐ Chỉ nói tiếng Việt
☐ Phần lớn noí tiếng Việt, một ít tiếng Anh
☐ Nưã tiếng Việt, nưã tiếng Anh
☐ Phần lớn nói tiếng Anh, một ít tiếng Việt
☐ Chỉ có tiếng Anh

18. Khả năng Anh ngữ của bạn như thế nào?

☐ Rất kém
☐ Hơi kém
☐ Khá giỏi
☐ Giỏi
☐ Rất thông thạo

19. Bạn có những người bạn thân nào?

☐ Chỉ có bạn người Việt
☐ Phần lớn bạn người Việt, một ít bạn người Mỹ
☐ Nưã số bạn người Việt, nưã số bạn người Mỹ
☐ Phần lớn bạn người Mỹ, một ít bạn người Việt
☐ Chỉ có bạn Mỹ

20. Bạn thích ăn loại thức ăn nào ?

☐ Chỉ có món Việt
☐ Phần lớn món Việt, một ít món Mỹ
☐ Nưã món Việt, nưã món Mỹ
☐ Phần lớn món Mỹ, một ít món Việt
☐ Chỉ ăn món Mỹ

21. Bạn thích xem chương trình truyền hình nào?

☐ Hầu hết chương trìnhViệt
☐ Đa số chương trìnhViệt, vài chương trình Mỹ
☐ Nưã chương trình Việt, nưã chương trình Mỹ
☐ Đa số chương trình Mỹ, vài chương trình Việt
☐ Chương trình Mỹ mà thôi

22 Bạn có thể thẩm định chính bạn như thế nào?
☐ Rất Việt Nam tính
☐ Đa số Việt Nam tính
☐ Nưã Việt, nưã Mỹ
☐ Đa số Mỹ tính
☐ Rất Mỹ hóa

Thành thật cảm tạ

BIBLIOGRAPHY

Aaronson, L. S. (1989). Perceived and received support: effects on health behavior during pregnancy. *Nursing Research, 38,* 4-9.

Abbott, J., Johnson, R., Koziol-McLain, J., & Lowenstein, S. R. (1995). Domestic violence against women: Incidence and prevalence in an emergency department population. *Journal of the American Medical Association, 273*, 1763-1767.

Abernethy, A.D., Chang, H. T., Seidltz, L., Evinger, J. S., & Duberstein, P. R. (2002). Religious coping and depression among spouses of people with lung cancer.
Source. *Psychosomatics, 43*(6), 456-463

Abraham, M. (2000). Isolation as a form of martial violence: The South Asian immigrant experiences. *Journal of Social Distress and the Homeless, 9*(3), 221-236.

Abramson, L. Y., Seligman, M. E. P., & Teasdale, J. P. (1978). Learned helplessness in humans: Critique and reformulation. *Journal of Abnormal Psychology, 87*, 49-74.

Aldwin, C., & Greenberger, E. (1987). Cultural differences in the predictors of depression. *American Journal of Community Psychology, 15,* 789-813.

Aldwin, C., & Revenson, T. A. (1987). Does coping help? A reexamination of the relation between coping and mental health. *Journal of Personality and Social Psychology, 53*(2), 337-348.

American Psychological Association (1996). *Violence and the Family: Report of the American Psychological Association Presidential Task Force on Violence and the Family*.

Anderson, J. C., & Gerbing, D. W. (1988). Structural equation modeling in practice: A review and recommended two-step approach. *Psychological Bulletin, 103*, 411-423.

Aneshensel, C. S., Pearlin, L. I., Mullan, J. T., Zarit, S. H., & Whitlach, C. J. (1995). *Profiles in caregiving: The unexpected career*. San Diego, CA: Academic Press.

Aranda, M., Castaneda, I., Lee, P., & Sobel, E. (2001). Stress, social support, and coping as predictors of depressive symptoms: Gender differences among Mexican Americans. *Social Work Research, 25*(1), 37-48.

Arias, I. (1999). Women's responses to physical and psychological abuse. In X. B. Arriaga & S. Oskamp (Eds.), *Violence in intimate relationships* (pp.139-161). Thousand Oaks, CA: Sage.

Asmundson, G. J. G., Frombach, I., McQuaid, J., Pedrelli, P., Lenox, R., & Stein, M. B. (2000). Dimensionality of posttraumatic stress symptoms: A confirmatory factor analysis of DSM-IV symptom clusters and other symptom models. *Behavioral Research and Therapy, 38*, 203-214.

Astin, M. C., Lawrence, K. J., & Foy, D. W. (1993). Posttraumatic stress disorder among battered women: Risk and resiliency factors. *Violence and Victims, 8,* 17-28.

Astin, M. C., Ogland-Hand, S. M., Coleman, E. M., & Foy, D. (1995). Posttraumatic stress disorder and childhood abuse in battered women: Comparison with martially distressed women. *Journal of Consulting and Clinical Psychology, 63*, 308-312.

Baron, R. M., & Kenny, D. A. (1986). The moderator-mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations. *Journal of Personality and Social Psychology, 51*, 1173-1182.

Barrerra, M. (1986). Distinction between social support concepts, measures, and models. *American Journal of Community Psychology, 14,* 413-445.

Baron, R. M., & Kenny, D. A. (1986). The moderator-mediator variable distinction in social psychological research: Conceptual, strategic and statistical considerations. *Journal of Personality and Social Psychology, 51*, 1173-1182**.**

Bates, D. S., & Toro, P. (1999). Developing measures to assess social support among homeless and poor people. *Journal of Community Psychology, 27*(2), 137-156.

Baum, A., Fleming, R. E., & Singer, J. E. (1983). Coping with technological disaster. *Journal of Social Issues, 39*, 117-138.

Bean, J., & Moeller, A. T. (2002). Posttraumatic stress and depressive symptomatology in a sample of battered women from South Africa. Psychological Reports, 90(3), 750-752.

Belle, D. (1990). Poverty and women's mental health. *American Psychologist, 45*, 385-389.

Bennice, J. A, Resick, P. A., Mechanic, M. (2003). The relative effects of intimate partner physical and sexual violence on posttraumatic stress disorder symptomatology. *Violence & Victims, 18*(1), 87-94

Bentler, P. M. (1990). Comparative fit indexes in structural models. P*sychometrika, 107*(2), 238-246.

Bentler, P. M., & Bonett, D. G. (1980). Significance tests and goodness of fit in the analysis of covariance structures. *Psychol Bull, 88*, 588-606.

Bergen, R. K. (1998). The reality of wide rape. In R. K. Bergen (Ed.), *Issues in intimate Violence* (pp.237-250). Thousand Oaks, CA: Sage.

Billings, A., & Moos, R. (1981). The role of coping responses and social resources attenuating the impact of stressful life events. *Journal of Behavioral Medicine, 4*, 139-147.

Billings, A., & Moos, R. (1985). Life stressors and social resources affect posttreatmetn outcome among depressed patients. *Journal of Abnormal Psychology, 94,* 140-153.

Bjorck, J. P., Cuthbertson, W., Thurman, J. W., & Lee, Y. (2001). Ethnicity, coping, and distress among Korean Americans, Filipino Americans, and Caucasian Americans. *Journal of Social Psychology, 141*(4), 421-443.

Blanchard, E. B., Jones-Alexander, J., Buckley, T. C., & Forneris, C. A. (1996). Psychometric properties of the PTSD checklist. *Behavioral Research of Therapy, 34*(8), 669-673.

Block, C. (1981). Black Americans and cross cultural counseling and psychotherapy experience. In A. Marsella & P. Pedersen (Eds.), *Cross cultural counseling and psychotherapy: Foundations, evolutions and cultural considerations*, New York: Pergamon Press.

Boes, M., & McDermott, V. (2002). Helping battered women: A health care perspective. In A. R. Roberts (Ed.), *Handbook of domestic violence intervention strategies* (pp.255- 277). New York: Oxford University Press.

Bolger, N. (1990). Coping as a personality process: A prospective study. *Journal of Personality and Social Psychology, 59*, 525-537.

Bollen, K. A. (1989). Structural Equations with Latent Variables. New York: Wiley.

Boumans, N. P., & Landeweerd, J. A. (1992). The role of social support and coping behavior in nursing work: Main or buffering effect. *Work & Stress, 6*(2), 191-202.

Brewster, M. P. (2002). Domestic violence theories, research, and practice implications. In A. R. Roberts (Ed.). *Handbook of domestic violence intervention strategies* (pp. 23-48). New York: Oxford University press.

Briere, J. (1992). Methodological issues in the study of sexual abuse effects. *Journal of Consult Clinical Psychology, 60,* 196-203.

Brook, D. W., Judith, S., Brook, L. R., Martin, W., Pe. T. W., Joseph, R. M., & Josephine, R. (1999). Coping strategies of HIV-positive and HIV-negative female injection drug users: A longitudinal study. *Aids Education and Prevention, 11*(5), 378-388.

Browne, A. (1993). Violence against women by male partners: Prevalence, outcomes, and policy implications. *American Psychologist, 48*, 1077-1087.

Browne, A. (1997). Violence in marriage: Until death do us part? In A. P. Cardarelli (Ed.), *Violence between intimate partners: Patterns, causes, and effects* (pp. 48-69). Needham Heights, MA: Allyn & Bacon.

Browne, A., & Finkelhoz, D. (1986). Impact of child sexual abuse: A review of the research. *Psychological Bulletin, 99*(1), 66-77.

Brugha, T. S., Bebbington, P. E., MacCarthy, B., Sturt, E., Wykes, T., & potter, J. (1990). Gender, social support, and recovery from depressive disorders: A prospective clinical study. *Psychological Medicine, 20*, 147-156.

Burt, M. R., & Katz, B. L. (1987). Dimensions of recovery from rape: Focus on growth outcomes. *Journal of Interpersonal Violence, 2*(1), 57-81.

Bybee, D. I., & Sullivan, C. M. (2002). The process through which an advocacy intervention resulted in positive change for battered women over time. *American Journal of Community Psychology, 30*(1), 103-132.

Carmen, E. H., Rieker, P. P., & Mills, T. (1984). Victims of violence and psychiatric illness. *American Journal of Psychiatry, 141*, 378-383.

Campbell, J. C., Miller, P., Cardwell, M. M., & Belknap, R. A. (1994). Relationship status of battered women over time. *Journal of Family Violence, 9*, 99-111.

Carson, B. (1997). A stress and coping approach to intervention with abused women. *Family Relations, 46*, 291-298.

Cascardi, M., & O'Leary, K. D. (1992). Depressive symptomatology, self-esteem, and self-blame in battered women. *Journal of Family Violence, 7*(4), 249-259.

Cascardi, M., O'Leary, K. D., Schlee, K. A. (1999). Co-occurrence and correlates of posttraumatic stress disorder and major depression in physically abused women. *Journal of Family Violence, 14*(3), 1999.

Catz, S. L., Gore-Felton, C., & McClure, J. B. (2002). Psychological distress among minority and low-income women living with HIV. *Behavioral Medicine, 28*(2), 53-60.

Centers for Disease Control and Prevention (2003), *Costs of Intimate Partner Violence Against Women in the United States.*

Chang, E. C. (1996). Cultural differences in optimism, pessimism, and coping: Predictors of subsequent adjustment in Asian American and Caucasian American college students. *Journal of Counseling Psychology, 43*(1), 113-123.

Chang, E. C. (2001). A look at the coping strategies and styles of Asian Americans: Similar or different? In C. R. Snyder (Ed.), *Coping with stress: Effective people and process* (pp.222-239). New York: Oxford University Press.

Chau, K. L. (1989). Sociocultural dissonance among ethnic minority populations. *Social Casework, 70*, 224-230.

Chemtob, C. M. (1996). Posttraumatic stress disorder, trauma, and culture. In F. L. Mak & C. C. Nadelson (Eds). *International review of psychiatry, 2,* 257-29.

Cheung, C., & Bagley, C. (1998). Validating an American scale in Hong Kong: The Center for Epidemiological Studies Depression Scale (CES-D). *Journal of Psychology, 132*(2), *169-186.*

Cheung, P., & Spears, G. (1995). Psychiatric morbidity among New Zealand Cambodians: The role of psychosocial factors. *Social Psychiatry and Psychiatric Epidemiology, 30*, 92-97.

Choi, A., & Edleson, J. L. (1996). Social disapproval of wife assaults: A national survey of Singapore. *Journal of Comparative Family Studies, 27*, 73-88.

Clements, C. M., & Sawhney, D. K. (2000). Coping with domestic violence: Control attributions, dysphoria, and hopelessness. *Journal of Traumatic Stress, 13*(2), 219-240.

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd, ed.). New York: Lawrence Erlbaum Associates, Inc.

Cohen, S., & Hoberman, H. (1983). Positive events and social supports as buffers of life change stress. *Journal of Applied Social psychology, 13*, 99-125.

Cohen, S., McKay, G. (1984). Social support, stress, and the buffering hypothesis: A theoretical analysis. In A. Baum, S. E., Taylor, & J. E. Singer (Eds.). *Handbook of psychology and health* (pp. 253-267). Hillsdale, NJ: Erlbaum.

Cohen, S., & Wills, T. A. (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin, 98*, 310-357.

Coker, A. L., Smith, P. H., Thompson, M. P., McKeown, R. E., Bethea, L., & Davis, K. E. (2002). Social support protects against the negative effects of partner violence on mental health. *Journal of Women's Health and Gender-Based Medicine, 11* (5), 465-476.

Council on Scientific Affairs (1992). Violence against women: Relevance for medical practitioners. *Journal of the American Medical Association, 267,* 3184-3189.

Cronkite, R. C., & Moos, R. H. (1984). The role of predisposing and moderating factors in the stress-illness relationship. *Journal of Health and Social Behavior, 25*, 372-393.

Cutrona, C. E., & Troutman, B. R. (1986). Social support, infant treatment, and parenting self-efficacy: A mediational model of postpartum depression. *Child Development, 57*, 1507-1518.

Dalton, C., & Schneider, E. M. (2001). *Battered women and the law*. New York: Foundation Press.

Dasgupta, S. D. (2000). Charting the course: An overview of domestic violence in the South Asian community in the United States. *Journal of Social Distress and the Homeless, 9*(3), 173-185.

Dean, A., & Lin, N. (1977). The stress buffering role of social support: Problems and prospects for systematic investigation. *Journal of Nervous Mental Disorders, 165*, 403-417.

DeGenova, M. K., Patton, D. M., Jurich, J. A., & MacDermid, S. M. (2001). Ways of coping among HIV-infected individuals. *Journal of Social Psychology, 134*(5), 655-663.

Dempsey, M. (2002). Negative coping as mediator in the relation between violence and outcomes: Inner-city African American youth. *American Journal of Orthopsychiatry, 72*(1), 102-109.

Dienemann, J., Boyle, E., Baker, D., Resnick, W., Wiederhorn, N., & Campbell, J. (2000). Intimate partner abuse among women diagnosed with depression. *Issues in Mental Health Nursing, 21*, 499-513.

Dobash, R. E., Dobash, R. P., & Cavanagh, K. (1985). The contact between battered women and social and medical agencies. In J. Pahl (Ed.), *Private violence and public policy: The needs of battered women and the response of the public services* (pp. 142-165). London: Routledge & Kegan Paul.

Dressler, W. W. (1985). The social and cultural context of coping: action, gender, and symptoms in a southern black community. *Social Science Medicine, 21*, 499-506.

Dunphy, L. M. (1999). *Management guidelines for adult nurse practitioners.* Philadelphia: Davis.

Dunst, C. J., Trivette, C. M., & Hanby, D. W. (1994). Measuring social support in families with young children with disabilities. In C. J. Dunst, C. M. Trivette, & Deal, A. G. (Eds.), *Supporting and strengthening families,* Cambridge*,* MA: Brookline Books.

Dussich, J. P. J. (2001). Decisions not to report sexual assault: A comparative study among women living in Japan who are Japanese, Korean, Chinese, and English-speaking. *International Journal of Offender Therapy and Comparative Criminology, 45*(3), 278-301.

Dutton, M. A. (1996). Battered women's strategic response to violence. In J. L. Edleson & Z. C. Eisikovits (Eds.), *Future interventions with battered women and their families* (pp. 105-124). Sage Series on Violence Against Women. Thousand Oak, CA: Sage.

Dutton, D. G., & Painter, S. (1993). Emotional attachments in abusive relationships: A test of traumatic bonding theory. *Violence and Victims, 8*(2), 105-120.

Falkum, E., Olff, M., Aasland, O. G. (1997). Revisiting the factor structure of the Ways of Coping Checklist: A three-dimensional view of the problem-focused coping scale: A study among Norwegian physicians. *Personality & Individual Differences, 22*(2), 257-267.

Felton, B. J., & Revenson, T. A. (1984). Coping with chronic illness: A study of illness controllability and the influence of coping strategies on psychological adjustment. *Journal of Consulting and Clinical Psychology, 52*, 342-353.

Fernandez, M. E., Mutran, E. J., & Reitzes, D. C. (1998). Moderating the effects of stress on depressive symptoms. *Research on Aging, 20*(2), 163-182.

Finn, J. (1985). The stresses and coping behaviors of battered women. *Social Casework: The journal of Contemporary Social Work* (June). 341-349.

Fischbach, R. L., & Herbert, B. (1997). Domestic violence and mental health: correlates and conundrums within and across cultures. *Social Science Medical, 45*(8), 1161-1176.

Fischer, J., & Corcoran, K. (1994). *Measures for clinical practice: A source book (2nd)*. Volume 2. New York: The Free Press.

Follingstad, D. R., Neckerman, A. P., & Vormbrock, J. (1988). Reactions to victimization and coping strategies of battered women: The ties that bind. *Clinical Psychological Review, 8*, 373-390.

Follingstad, D. R., Brennan, A. F., Hause, E. S., Polek, D. S., & Rutledge, L. L. (1991). Factors moderating physical and psychological symptoms of battered women. *Journal of Family Violence, 6*(1), 81-95.

Folkman, S., & Lazarus, R. S. (1980). An analysis of coping in a middle-aged community sample. *Journal of Health Social Behavioral, 21*, 219-239.

Folkman, S., & Lazarus, R. S. (1985). If is changes it must be a process: A study of emotion and coping during three stages of a college examination. *Journal of Personality and Social Psychology, 48,* 150-170.

Folkman, S., Lazarus, R. S., Dunkel-Schetter, C., Delongis, A., & Gruen, R. J. (1986). Dynamics of a stressful encounter: Cognitive appraisal, coping and encounter outcomes. *Journal of Personality and Social Psychology, 50*, 571-579.

Fondacaro, M. R., & Moos, R. H. (1987). Social support and coping: A longitudinal analysis. *American Journal of Community Psychology, 15*, 653.

Forsythe, C. J., & Compas, B. E. (1987). Interaction of stressful events and coping: Testing the goodness of fit hypothesis. *Cognitive Therapy and Research, 11*, 473-485.

Fox, C. A., Blanton, P. W., Morris, M. L. (1999). Religious problem-solving styles: Three styles revisited. *Journal for the Scientific Study of Religion, 37*(4), 673-677.

Foy, D. W., Sipprelle, R. C., Rueger, D. B., & Carroll, E. M. (1984). Etiology of posttraumatic stress disorder in Vietnam veterans: Analysis of premilitary, military and combat exposure influences. *Journal of Consulting Clinical Psychology, 52*, 79-87.

Fry, P. S., & Grover, S. C. (1982). Cognitive appraisals of life stress and depression in the elderly: A cross-cultural comparison of Asian and Caucasians. *International Journal of Psychology, 17*(4), 437-454.

Garner, J., & Fagan, J. 91997). Victims of domestic violence. In R. C. Davis, A. J. Lurigio, & W. G. Skogan (Eds.), *Victims of crime* (2nd ed., pp. 53-85). Thousand Oaks, CA: Sage.

Gary, L. (1985). Attitudes toward human services organizations: Perspectives from an urban black community. *Journal of Applied Behavioral Science, 21*, 445-458.

Gelles, R. (1979). *Family Violence*. Beverly Hills, CA: Sage.

Gelles, R., & Harrop, J. (1989). Violence, battering and psychological distress among women. *Journal of Interpersonal Violence, 4*(4), 400-420.

Gelles, R., & Straus, M. (1988). *Intimate violence: The definitive study of causes and consequences of abuse in the American family*. New York: Simon and Schuster.

Gil, V., & Anderson, A. F. (1999). Case study of rape in contemporary China. *Journal of Interpersonal Violence, 14*(11), 1151-1171.

Giles-Sims, J. (1998). The aftermath of partner violence. In J. L. Jasinski & L. M. Williams (Eds), *Partner violence: A comprehensive review of 20 years of research* (pp. 44-72). Thousand Oaks, CA: Sage.

Gleason, W. J. (1993). Mental disorders in battered women: A empirical study. *Violence and Victims, 8*, 53-68.

Golding, J. M. (1999). Intimate partner violence as a risk factor for mental disorders: A meta-analysis. *Journal of Family Violence, 14*, 99-133.

Golding, J. M., & Burnam, M. A. (1990). Immigration, stress, and depressive symptoms in a Mexican-American community. *Journal of Nervous and Mental Disorder, 178*, 161-171.

Gondolf, E. W., Fisher, E., & McFerron, J. R. (1988). Racial differences among shelter residents: A comparison of Anglo, Black, and Hispanic battered women. *Journal of Family Violence, 3*, 39-51.

Grandin, E., Lupri, E., & Brinkerhoff, M. B. (1998). Couple violence and psychological distress. *Canadian Journal of Public Health, 89*(1), 43 - 57.

Hall, L. A., Williams, C. A., & Greenberg, R. S. (1985). Supports, stressors, and depressive symptoms in low-income mothers of young children. *American Journal of Public Health, 75*, 518-522.

Hamby, S. L., & Gray-Little, B. (1997). Responses to partner violence: Moving away from deficit model. *Journal of Family Psychology, 11*, 339-350.

Hays, R. D., Marshall, G. N., Wang, E.Y.I., & Sherbourne, C. D. (1994). Four-year cross-lagged associations between physical and mental health in the medical outcomes study. *Journal of Consulting and Clinical Psychology, 62*, 441-449.

Hair, J. F, Anderson, R. E, Tathan, R. L., & Black, W. C. (1998). *Multivariate data analysis, with readings* (4th ed.). Englewood Cliffs, NJ: Prentice Hall

Hattendorf, J., Ottens, A. J., & Lomax, R. G. (1999). Type and severity of abuse and posttraumatic stress disorder symptoms reported by women who killed abusive partners. *Violence Against Women, 5*(3), 292-312.

Hein, D. A., Edward, N., Frances, R., L., & Deborah F. (2000). Posttraumatic stress disorder and short-term outcome in early methadone. *Journal of Substance Abuse Treatment 19*(1), 31-37.

Heise, L. (1993). Violence against women: the missing agenda. In M. Koblinski, J. Timyan, & J. Gay (Eds.). *Women's health: A global perspective* (pp.171-195). Westview, Boulder.

Hendrick-Matthews, M. (1982). The battered woman: Is she ready for help? *Journal of Family Violence, 12*, 169-191.

Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress, 5*, 271-391.

Ho, C. (1990). An analysis of domestic violence in Asian American communities: A multicultural approach to counseling. *Women and Therapy, 9*, 129-150.

Hobfoll, S., & Vaux, R. (1993). Gender differences in preference to offer social support to assertive men and women. *Sex Roles: A Journal of Research, 28*(7), 419-433.

Holohan, C. J., & Moos, R. H. (1990). Life stressors, resistance factors, and psychological health: An extension of the stress-resistance paradigm. *Journal of Personality and Social Psychology, 58*, 909-917.

Hoff, L. (1990). *Battered women as survivors*. London: Sage.

Hong, W., Yamamoto, J., Chang, D. S., & Lee, F. (1993). Sex in a Confucian society. *Journal of the American Academy of Psychoanalysis, 21*(3), 405-419.

Hox, J. J., & Bechger, T. M. (1998*). An introduction to structural equation modeling. Family Science Review, 11*, 354-373.

Hu, L. T., & Bentler, P. (1995). Evaluation model fit. In R. H. Holye (Ed.), *Structural Equation Modeling, concepts, issues, and applications* (pp. 76-99). Newbury Park, CA: Sage.

Huang, C. J., & Gunn, T. (2001). An examination of domestic violence in an African American community in North Carolina: Causes and consequences. *Journal of Black Studies, 31*(6), 790-811.

Hughes, M., & Jones, L. (2000). *Women, domestic violence, and posttraumatic stress disorder.* California State University Faculty Research Fellows Program for the California Governor's Office of Planning and Research.

Hutchison, L. W., & Hirschel, J. D. (1998). Abused women: Help –seeking strategies and police utilization. *Violence Against Women, 4*, 436-456.

Jackson, T. L., Petretic-Jackson, A., & Witte, T. H. (2002). Mental health assessment tools and techniques for working with battered women. In A. R. Roberts (Ed.). *Handbook of domestic violence intervention strategies* (pp. 321-342). New York: Oxford University press.

Jamieson, N. (1993). *Understanding Vietnam*. Berkeley CA: University of California Press.

Jones, L., Hughes, M., & Unterstaller, U. (2001). Post-traumatic stress disorder (PTSD) in victims of domestic violence: A review of the research. *Trauma, Violence and Abuse, 2*, 99-119.

Janoff-Bulman, R., & Frieze, I. H. (1983). A theoretical perspective for understanding reactions to victimization. *Journal of Social Issues, 39*, 1-17.

Josepho, S. A., & Plutchik, R. (1994). Stress, coping, and suicide risk in psychiatric patients. *Suicide and Life-Threatening Behavioral, 24*, 48-57.

Joreskog, K.G. & Sorbom, D. (1982). Recent developments in structural equation modeling. *Journal of Marketing Research*, *19*, 404-416.

Kali, A., Rosen, D., Gruber, G., & Tolman, R. (1999). *Impact of domestic violence and mother's well-being on children in families receiving welfare benefits.* Paper presented at Domestic Violence, and child protection, and welfare reform. Trapped by poverty and abuse. Conference sponsored by the project for research on welfare, work, and domestic violence, sponsored by the Taylor Institute and University of Michigan's Center on Poverty, Risk, and Mental Health, April 17, 1998.

Kaniasty, K., & Norris, F. (1993). A test of the social support deterioration model in the context of natural disaster. *Journal of Personality and Social Psychology, 64,* 395-340.

Kaslow, N. J., Thompson, M. P., Meadows, L. A., Jacobs, D., Gibb, B., Bornstein, H., Hollins, L., & Rashid, A. (1998). Factors that mediate and moderate the link between partner abuse and suicidal behavioral in African American women. *Journal of Consulting and Clinical Psychology, 66*(3), 533-540.

Kelly, L. (1988). How women define their experiences of violence. In K. Yllo & M. Bogard (Eds.), *Feminist perspectives on wife abuse* (pp. 114-132). Newbury Park, CA: Sage.

Kemp, A., Green, B., Hovawitz, C., & Rawlings, E. (1995). Incidence and correlates of post-traumatic stress disorder in battered women: Shelter and community samples. *Journal of Interpersonal Violence, 10*, 43-55.

Kemp, A., Rawlings, E. I., Green, B. L. (1991). Post-traumatic stress disorder in battered women: A shelter sample. *Journal of Traumatic Stress, 4*, 137-148.

Kendall-Tackett, K. A., Williams, L. M., & Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychological Bulletin, 113*(1), 164-180.

Kibria, N. (1993). *Family tightrope: The changing lives of Vietnamese Americans*, Princeton, NJ: Princeton University Press.

Kim, O. (1999). Mediation effect of social support between ethnic attachment and loneliness in older Korean immigrants. *Research in Nursing and Health, 22*, 169-175.

Kline, R. B. (1998). *Principles and Practice of Structural Equation Modeling*. New York: Guilford

Klein, E., Campbell, J. C., Soler, E., & Chez, M. (1997). *Ending the violence.* Thousand Oaks, CA: Sage Publications.

Koenig, H. G., Linda K. G., Keith G. M., Dan G. B., & Dyck, P. B. (1994). Religious affiliation and psychiatric disorder among protestant baby boomers. *Hospital and Community Psychiatry, 45,* 586-96.

Lancaster, L. R. (1984). Buddhism and family in East Asia. In G. A. De Vos & T. Sofue (Eds.), *Religion and the family in East Asia* (pp. 35-54). Berkeley: University of California Press.

Laviolette, A. D., & Barnett, O. W. (2000). *It could happen to anyone: Why battered women stay*. Thousand Oak, CA: Sage.

Lawton, M. P., Moos, M. Kleban, M. H., Glicksman, A., & Rovine, M. (1991). A two-factor model of caregiving appraisal and psychological well-being. *Psychological Sciences, 46*, 181-189.

Lazarus, R. (1966). *Psychological stress and the coping process*. New York: McGraw-Hill.

Lazarus, R. (1981). The stress and coping paradigm. In C. Eisdorfer, D. Cohen, A. Kleinman, & P. Maxim (Eds.), *Models for clinical psychopathology* (pp. 177-214). New York: Spectrum.

Lazarus, R. (1993). Coping theory and research: Past, present, and future. *Psychosomatic Medicine, 55*, 234-247.

Lazarus, R., & Folkman, S. (1984). *Stress, appraisal and coping*. New York: Springer.

Lee, M. (2002). Asian battered women. In A. R. Roberts (Ed.). *Handbook of domestic violence intervention strategies* (pp. 472-482). New York: Oxford University press.

Lee, H., & Cheung, F. M. (1991). The attitudes toward rape victim scale: Reliability and validity in a Chinese context. *Sex Roles, 24*, 599-603.

Lee, R. M., & Liu, H. T. (2001). Coping with intergenerational family conflict: Comparison of Asian Americans, Hispanic, and European American college students. *Journal of Counseling Psychology, 48*(4), 410-419.

Lee, M., Crittenden, K., & Yu, E. (1996). Social support and depression among elderly Korean immigrants in the United States. *International Journal of Aging and Human Development, 42*, 313-327.

Lehmann, D. R., Ellard, J. H., & Wortman, C. B. (1986). Social support for the bereaved recipients' and providers' perspectives on what is helpful. *Journal of Consulting and Clinical Psychology, 54*, 438-446.

Levin, J. S., Kyriakos S. M., & Laura A. R. (1996). Religious Attendance and Psychological Well-Being in Mexican Americans: A Panel Analysis of Three Generations Data. *Gerontologist, 36*, 454-63.

Levin, J S., Linda M. C., & Robert J. T. (1995). Religious Effects on Health Status and Life Satisfaction among Black Americans. *Journal of Gerontology: Social Sciences, 50*, 154-163.

Liang, B., & Bogat, A. (1994). Culture, control, and coping: New perspectives on social support. *American Journal of Community Psychology, 22*, 123-147.

Lin, N., Ensel, W., Simeone, R., & Kuo, W. (1979). Social support, stressful life events, and illness: A model and empirical test. *Journal of Health and Social Behavior, 20*, 108-119.

Lin, N., Simeone, R. S., Ensel, W. M., & Kuo, W. (1979). Social support, stressful life events, and illness: A model and an empirical test. *Journal of Health and Social Behavior, 20*, 108-119.

Littrell, J., & Beck, E. (2001). Predictors of depression in a sample of African-American homeless men: Identifying effective coping strategies given varying levels of daily stressors. *Community Mental Health Journal, 37*(1), 15-29.

Loehlin, J. C. (1998). *Latent variable models: An introduction for factor, path, and structural models* (3rd ed.). NJ: Erlbaum.

Lum, J. (1998). Family violence. In L. C. Lee & N. W. S. Zane (Eds.), *Handbook of Asian American psychology* (pp. 505-525). Thousand Oaks, CA: Sage.

Manne, S. L., & Zautra, A. J. (1989). Spouse criticism and support: Their association with coping and psychological adjustment among women with rheumatoidarthritis. *Journal of Personality and Social Psychology, 56*, 608-617.

Marin, G., Sabogal, R., Marin, B., Otero-Sabogal, R., & Perez-Stable, E. (1987). Development of a short acculturation scale for Hispanics. *Hispanic Journal of Behavioral Science, 9*, 183-205.

Marsella, A. J., & Snyder, K. K. (1981). Stress, social supports and schizophrenic disorders: Toward an interactional model. *Schizophrenia Bulletin, 7*, 152-163.

McColl, M. A., Lei, H., & Skinner, H. (1995). Structural relationships between social support and coping. *Social Science Medicine, 41*(3), 395-407.

McCrae, R. R., & Costa, P. T. (1986). Personality, coping, and coping effectiveness in an adult sample, *Journal of Personality, 54*, 385-405.

McCubbin, M. A.(1989). Family stress and family strengths: a comparison of single and two parent families with handicapped children. *Research in Nursing and Health, 12*, 101-110.

McDonnell, K., & Abdulla, S. E. (2001). *Project AWARE.* Washington, DC: The Asian/Pacific Islander Domestic Violence Resource Project

Merchant, M. (2000). A comparative study of agencies assisting domestic violence victims: Does the South Asian community have special needs? *Journal of Distress and the Homeless, 9*(3), 249-259.

Mitchell, R. E., & Hodson, C. A. (1983). Coping with domestic violence: Social support and psychological health among battered women. *American Journal of Community Psychology, 11*, 629-654.

Mitchell, R. E., & Hodson, C. A. (1986). Coping and social support among battered women: An ecological perspective. In S. E. Hobfol (Ed), *Stress, social support, and women. The series in clinical and community psychology* (pp. 153-169*).* Washington: Hemisphere Pub. Corp.

Molassiotis, A, van den Akker, O. B, & Boughton, B. J. (1997). Perceived social support, family environment and psychosocial recovery in bone marrow transplant long-term survivors. *Social Science and Medicine, 44*(3), 317-325.

Mokuau, N. (1987). Social workers' perceptions of counseling effectiveness for Asian American clients. *Journal of National Association of Social Workers, 32,* 331-335.

Mui, A. (1996). Depression among elderly Chinese immigrants: an exploratory study. *Social Work, 41*(6), 633-645.

Neff, J. A. (1993). Life stressors, drinking patterns, and depressive symptamatology: Ethnicity and stress-buffer effects of alcohol. *Addictive Behavior, 18,* 373-387.

Nicholson, B. L. (1997). The influence of pre-emigration and postemigration stressors on mental health: A study of Southeast Asian refugees. *Social Work Research, 21*(1), 19-32.

Monroe, S. M., Bromet, E. J., Connell, M. M., Steiner, S. (1986). Social support, life events, and depressive symptoms: A 1-year prospective study. *Journal of Consulting and Clinical Psychology, 54*(4), 424-431.

Noh, S., & Avison, W. (1996). Asian immigrants and the stress process: A study of Korean in Canada. *Journal of Health and Social Behavior, 37*, 192-206.

Norris, F. H. (1992). Epidemiology of truma: Frequency and impact of different potentially traumatic events on different demographic groups. *Journal of Consulting and Clinical Psychology, 60*(3), 409-418.

Norris, F., & Kaniasty, K. (1996). Receipt of help and perceived social support in times of stress. A test of the delterioration deterrence model. *Journal of Personality and Social Psychology, 71*, 498-511.

Nurius, P. S., Furrey, J., & Berliner, L. (1992). Coping capacity among with abusive partners. *Violence and Victims, 7*, 229-243.

Oh, Y., Koeske, G. F., & Sales, E. (2002). Acculturation, stress, and depressive symptoms among Korean immigrants in the United States. *Journal of Social Psychology, 142*(4), 511-526.

Okamura, A., Heras, P., Wong-Kerberg, L. (1995). Asian, Pacific Island, and Filipino Americans and sexual child abuse. In L. A. Fontes (Ed.). *Sexual abuse in nine North American cultures* (pp. 67-96). Thousand Oak, CA: Sage.

O'Leary, K. D. (1999). Psychological abuse: A variable deserving critical attention in domestic violence. *Violence and Victims, 14*(1), 3-23.

Paolucci, E. O., Genuis, M. L., & Violato, C. (2001). A meta-analysis of the published research on the effects of child sexual abuse. *Journal of Psychology, 135*(1), 17-36.

Pargament, K. I., Kennell, W., Hathaway, N., Gravengoed, J., Newman, J., & Jones, W. (1988). Religion and the problem-solving process: Three styles of coping. *Journal for the Scientific Study of Religion, 27,* 90-104.

Park, I. H., & Cho L. (1995). Confucianism and the Korean Family. *Journal of Contemporary Family Studies, 26*(1), 117-134.

Pederson, P. (1991). Balance as a criterion for social services for Asian and Pacific Islander Americans. In N. Mokuau (Ed.), *Handbook of social services for Asians and Pacific islanders* (pp.37-57). New York: Greenwood Press.

Penley, J. A., Tomaka, J., & Wiebe, J. S. (2002). The association of coping to physical and psychological health outcomes: A meta-analytic review. *Journal of Behavioral Medicine, 25*(6), 551-603.

Petretic-Jackson, A., Witte, T. H., & Jackson, T. L. (2002). Battered women: Treatment goals and treatment planning. In A. R. Roberts (Ed.). *Handbook of domestic violence intervention strategies* (pp. 321-342). New York: Oxford University press.

Ping, R.A. (2004), *Testing Latent Variable Models with Survey Data,* 2nd Edition, [on-line monograph], www.wright.edu/~robert.ping/lv1/toc1.htm

Plante, T. G., & Boccaccini, M. T. (1997). The Santa Clara Strength of Religious Faith Questionnaire. *Pastoral Psychology, 45,* 429-437.

Pruchno, R. A., & Resch, N. L. (1989). Mental health of caregiving spouses: Coping as mediator, moderator, or main effect. *Psychology and Aging, 4*(4), 454-463.

Ptacek, J. T., Pierce, G. R., & Ptacek, J. J. (2002). The social context of coping with prostate cancer. *Journal of Psychosocial Oncology, 20*(1), 61-80.

Quittner, A. L., Gluechauf, R., & Jackson, D. N. (1990). Chronic parenting stress: Moderating versus mediating effects of social support. *Journal of Personality and Social Psychology, 59*, 1266-1278.

Randolf, L. S. (1977). The CES-D scale: a self-report depression scale for research in the general population. *Applied Psychological Measurement, 1*, 385-401.

Rao, K., Diclemente, R. J., Ponton, L. E. (1992). Child sexual abuse of Asian compared with other populations. *Journal of American Academy of Child and Adolescent Psychiatry, 31*(5), 880-886.

Regehr, C., Hemsworth, D., & Hill, J. (2001). Individual predictors of posttraumatic distress: A structural equation model. *Canadian Journal of Psychiatry, 46,* 156-161.

Rennison, C. M., & Welchans, S. A. (2000). *Intimate partner violence.* Washington, DC: Bureau of Justice Statistics.

Rhode, P., Tilson, M., Lewinsohn, P. M., & Seeley, J. R. (1990). Dimensionality of coping and its relation to depression. *Journal of Personality and Social Psychology, 58,* 499-511.

Roberts, A. R. (2002). Duration and severity of women battering. In A. R. Roberts (Ed.), *Handbook of domestic violence intervention strategies* (pp.64- 79). New York: Oxford University Press.

Robinson, J. P., Shanver, P. R., & Wrightsman, L S. (1991). Criteria for scale selection and evaluation. In J. P. Robinson, P.R. Shanver, & L.S. Wrightsman, L S. (Eds.), *Measures of personality and social psychological attitudes* (pp. 1-35). San Diego, CA: Academic Press.

Rokach, A. (1999). Cultural background and coping with loneliness. *Journal of Psychology, 133*(2), 217-229.

Raykov, T., & Marcoulides, G. A. (2000). *A First Course in Structural Equation modeling*. Mahwah, NJ: Lawrence Erlbaum.

Rollstin, A. O., & Kern, J. M. (1998). Correlates of battered women's psychological distress: Severity of abuse and duration of the postabuse period. *Psychological Reports, 82,* 387-394.

Ross, C. E. (1990). Religion and psychological distress. *Journal for the Scientific Study of Religion, 29*(2), 236-245.

Roth, J. K. (1997). *Encyclopedia of social issues* (Vol. 2). Tarrytown, NY: First Printing.

Roth, S., Wayland, K., & Woolsey, M. (1990). Victimization history and victim-assailant relationships as factors in recovery from sexual assault. *Journal of Traumatic Stress, 3*, 169-180.

Runtz, M., & Schallow, J. R. (1997). Social support and coping strategies as mediators of adult adjustment following childhood maltreatment. *Child Abuse and Neglect, 21*(2), 211-226.

Russell, D., & Cutrona, C. (1984). *The provision of social relationships and adaptation to stress*. A paper presented at the annual meeting of the American Psychological Association, Toronto, Canada.

Sarason, B., Shearin, E., Pierce, G., & Sarason, I. (1987). Interactions of social support measures: Theoretical and practical implications. *Journal of Personality and Social Psychology, 52*(4), 813-832.

Sato, R. A., & Heiby, E. M. (1992). Correlates of depressive symptoms among battered women. *Journal of Family Violence, 7*, 229-245.

Schaefer, C., Coyne, J. C., & Lazarus, R. S. (1981). The health-related functions of social support. *Journal of Behavioral Medicine, 4*, 381-406.

Schiff, M., El-Bassel, N., Engstrom, M., Gilbert, L. (2002). Psychological distress and intimate physical and sexual abuse among women in methadone maintenance treatment programs. *Social Service Review, 76*(2), 302-320.

Schumacker, R. E., & Lomax, R. C. (1996). *A beginner's guide to structural equation modeling*. Mahwah, NJ: Erlbaum.

Seligman, M. E. P. (1975). *Helplessness: On depression, development and death.* San Francisco, CA: Freeman,

Sheu, S., Lin, H., & Hwang, S. (2002). Perceived stress and physio-psycho-social status of nursing during their initial period of clinical practice: The effect of coping behaviors. *International Journal of Nursing Studies, 39*(2), 165-175.

Shin, H. L. (1995). Violence and intimacy: Risk markers and predictors of wife abuse among Korean immigrants. Unpublished docoral dissertation. University of Southern California, Los Angeles, CA.

Shon, S., & Ja, D. (1982). Asian families. In M. McGoldrick, J. Pearce, & J. Giordano (Eds.), *Ethnicity and family therapy* (pp.208-229). New York: Guilford Press.

Snowden, L. R., & Cheung, F. K. (1990). Use impatient mental health services by members of ethnic minority groups. *American psychologist, 45*, 347-355.

Song, Y. I. (1996). *Battered women in Korean immigrant families.* New York: Garland.

Steel, J. L., Wilson. G., Cross, H., & Whipple, J. (1996). Mediating factors in the development of psychology in victims of childhood asexual abuse. *Sexual Abuse: Journal of Research and Treatment, 8*(4), 291-316.

Stein, M., & Kennedy, C. (2002). Major depressive and post-traumatic stress disorder comorbidity in female victims of intimate partner violence. *Journal of Affective Disorder, 66*(2-3), 133-138.

Stein, C. H., & Rappaport, J. (1986). Social network interviews as sources of etic and emic data: A study of young married women. In S. E. Hobfoll (Ed.), *Stress, social support, and women* (pp. 47-66). New York: Hemisphere Publishing Corporation.

Straus, M. A.(1979). Measuring intrafamily conflict and violence: The Conflict Tactics Scales. *Journal of Marriage and the Family, 41*, 75-88.

Straus, M. A., Hamby, S. L., Boney-McCoy, S., & Sugarman, D. B. (1996). The revised conflict tactics scales (CTS2). *Journal of Family Issues, 17*(3), 283-316.

Straus, M. A., & Gelles, R. J. (1990). How violent are American families? Estimates from the national family violence survey and other studies. In M. A. Straus & R. J. Gelles (Eds.), *Physcial violence in American families: Risk factors and adaptations to violence in 8,145 families* (pp. 95-112). New Brunswick, NJ: Transaction Publishing.

Straus, M. A., & Kantor, G. K. (1990). Response of victims and the police to assaults on wives. In M. A. Straus & R. J. Gelles (Eds.), *Physical violence in American families: Risk factors and adaptation to violence in 8, 145 families* (pp. 473-487). New Brunswick, NJ: Transaction.

Strentz, T., & Auerbach, S. M. (1988). Adjustment to the stress of simulated capacity: Effects of emotion-focused versus problem-focused preparation on hostages differing in locus of control. *Journal of Personality and Social Psychology, 55*, 652-660.

Sullivan, C. (1991). The provision of advocacy services to women leaving abusive partners. *Journal of Interpersonal Violence, 6*, 41-54.

Sullivan, C., & Rumptz, M. (1994). Adjustment and needs of African American women who utilized a domestic violence shelter. *Violence and Victims, 9*, 275-286.

Sullivan, C. M., Tan, C., Basta, J., Rumptz, M., & Davidson, W. S. (1992). An advocacy intervention program for women with abusive partners: Initial evaluation. *American Journal of Community Psychology, 20*(3), 309-333.

Suls, J., & Fletcher, B. (1985). The relative efficacy of avoidant and non-avoidant coping strategies: A meta-analysis. *Health Psychology, 4*, 249-288.

Tabachnick, B.G., & Fidell, L.S. (1996). *Using multivariate statistics* (3rd ed.). New York: Harper Collins.

Tan, C., Basta, J., Sullivan, C. M., & Davidson, W. S. (1995). The role of social support in the lives of women existing domestic violence shelters. *Journal of Interpersonal Violence, 12*, 437-451.

Tanaka, J. S., & Huba, G. J. (1985). A fit index for covariance structure models under arbitrary GLS estimation. *British Journal of Mathematical and Statistical Psychology*, *38*, 197-201.

Thoits, P. A. (1986). Social support as coping assistance. *Journal of Consulting and Clinical Psychology, 54*(4), 416-423.

Thompson, M. P., Kaslow, N. J., Kingree, J. B., Rashid, A., Puett, R., Jacobs, D., & Matthews, A. (2000). Partner violence, social support, and distress among inner-city African-American women. *American Journal of Community Psychology, 28*(1), 127-143.

Tjaden, P., & Thoennes, N. (1998). *Prevalence, incidence, and consequences of violence against women: Findings from the National Violence Against Women Survey.* Washington, DC: U.S. Department of Justice. NCJ No. 172837.

Tran, C. G. (1997). *Qualitative analyses of domestic violence in Vietnamese refugee women*. Manuscript submitted for publication.

Tran, C. G., & Jardins. K. D. (2000). Domestic violence in Vietnamese refugee and Korean immigrant communities. In J. L. Chin (Ed.), *Relationships among Asian American women* (pp. 71-96). Washington, DC: American Psychological Association.

Tuel, B. D., & Russell, R. K. (1998). Self-esteem and depression in battered women: A comparison of lesbian and heterosexual survivors. *Violence Against Women, 4,* 344-363.

Turner, H. A., Catania, J. A. (1997). Informal caregiving to persons with AIDS: Caregiver characteristics, conditions, and burden among 18-49 year olds living in U.S. central cities. *American Journal of Community Psychology, 25,* 35-59.

Turner, R. J., Frankel, B. G., & Levin, D. M. (1983). Social support: conceptualization, measurement, and implications for mental health. In J. R. Greeley (Ed.), *Research in community and mental health* (pp. 67-111). Greenvich, CT: JAI Press.

Ullman, J. B. (2001). *Structural equation modelling. In B.G. Tabachnick, & L.S. Fidel (Eds), Using Multivariate Statistics* (4th ed.) (pp. 653- 771). Needham Heights, MA: Allyn & Bacon.

Um, C.C., & Dancy, B. L (1999). Relationship between coping strategies and depression among employed Korean immigrant wives. *Issues in Mental Health Nursing, 20* (5), 485-94.

U.S. Department of Commerce (2002). *The Asian population: 2000*. Washington, DC: U.S. Government Printing Office.

Valentiner, D. P., Holahan, C. J., & Moos, R. H. (1994). Social support, appraisals of event controllability, and coping: An integrative model. *Journal of Personality and Social Psychology, 66*, 1094-1102.

Vitaliano, P. P., Russo, J., Carr, J. E., Maiuro, R. D., & Becker, J. (1985). The ways of coping checklist: revision and psychometric properties. *Multivariate Behavioral Research, 20*, 3-26.

Vitanza, S., Vogel, L. C. M., & Marshall, L. L. (1995). Distress and symptoms of posttraumatic stress disorder in abused women. *Violence and Victims, 10*(1), 23-34.

Vivian, D., & Malone, J. (1997). Relationship factors and depressive symptomatology associated with mild and severe husband-to-wife physical aggression. *Violence and Victims, 12*, 3-18.

Vogel, L. C. M., & Marshall, L. L. (2001). PTSD symptoms and partner violence: Low income women at risk. *Journal of Traumatic Stress, 4*(3), 569-584.

Wallace, H., & Seymour, A. (1999). *National victim assistance academy* (Chap. 8: Domestic Violence). Available at http://www.ojp.usdoj.gov/ovc/assist/nvaa99chap8.htm.

Walker, L. E. (1977). Battered women and learned helplessness. *Victimology: An International Journal, 2*, 525-534.

Wauchope, B. A. (1988). *Help-seeking decisions of battered women: A test of learned helplessness and two stress theories.* Durham: University of New Hampshire, Family Violence Research Program.

Weathers, F. W., Litz, B. T., Herman, D. S., Husk, J. A., Keane, T. M. (1993). *The PTSD cheklist: Reliability, validity, & diagnosis utility*. Paper presented at the annual meeting of the International Society for Traumatic Stress Studies. San Antonio, TX.

Weinberger, M., Tierney, W. M., Booher, P., & Hiner, S. L. (1990). Social support, stress and functional status in patients with osteoarthritis. *Social Science Medicine, 30*(40), 503-508.

Wethington, E., & Kessler, R. C. (1986). Perceived support, received support and adjustment to stressful life events. *Journal of Health and Social Behavior, 27*, 78.

Williams, David R.; Larson, David B.; Buckler, Robert E. (1991). Religion and psychological distress in a community sample. *Social Science & Medicine, 32*(11), 1257-1262.

Wyatt, G. E., Notgrass, C. M., & Newcomb, M. (1990). Internal and external mediators of women's rape experience. *Psychology of Women Quarterly, 14*, 153-176.

Yamashiro, G., & Matsuoka, J. K. (1997). Help-seeking among Asian and Pacific Americans: A multiperspective analysis. *Social Work, 42*(2), 176-186.

Yates, M. E., Tennstedt, S., & Chnag, B. (1999). Contributors to and mediators of psychological well-being for informal caregivers. *Journal of Gerontology, 54*(B-1), 12-22.

Yick, A. G. (2000). Domestic violence beliefs and attitudes in the Chinese American community. *Journal of Social Service Research, 27*(1), 29-51.

Yick, A. (2000). Predictors of physical spousal intimate partner violence in Chinese American families. *Journal of Family Violence, 15*, 249-267.

Yoshihama, M. (1999). Domestic violence against women of Japanese descent in Los Angeles: Two methods of estimating prevalence. *Violence Against Women, 5*, 896-897.

Yoshihama, M. (2002). Battered women's coping strategies and psychological distress: Differences by immigration status. *American Journal of Community Psychology, 30*(3), 429-452.

Yoshioka, M., Dang, Q, Shewmangal, N., Vhan, C., & Tan, C. I. (2000). *Asian family violence report: A study of the Cambodian, Chinese, Korean, South Asian and Vietnamese communities in Massachusetts*. Boston, Massachusetts: Asian Task Force Against Domestic Violence, Inc.

Zea, M., Jarama, S., & Bianchi, F. (1995). Social support and psychological competence: Explaining the adaptation to college of ethnically diverse students. *American Journal of Community Psychology, 23*, 509-531.

Zeidner, M., & Endler, N. (1996). *Handbook of coping: Theory, research, applications*. New York: Wiley & Sons, Inc.

.

VITA

Joohee Lee was born in Seoul, South Korea on February 13, 1969, the daughter of Yongchil Lee and Yunoh Park. After completing Yong Dong Girls' High School, Seoul, South Korea in 1987, she entered Ewha Women's University, Seoul, South Korea and received her Bachelor of Arts degree in 1991 and Master of Arts degree in 1993. During the following years she worked as a high school teacher in Seoul Korea. In 1998, she entered the School of Social Work at the University of South Carolina, Columbia, South Carolina and received her Master of Social Work degree in 2000. In 2000, she entered the School of Social Work at the University of Texas at Austin. During her studies at the University of Texas at Austin, she worked as a research assistant of the Gulf Coast Addiction Technology Transfer Center. She also worked with Saheli as a board member and diversity chair

Permanent address: 2300 Lincoln Road Apt # 140

Hattiesburg, MS 39401

This dissertation was typed by the author.